FEHB PROGRAM AS A COMPLEMENT TO MILITARY CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

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FEHB PROGRAM AS A COMPLEMENT TO MILITARY HEALTH CARE

TUESDAY, APRIL 28, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:30 p.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Pappas, Cummings, and Norton.

Staff present: George Nesterczuk, staff director; Garry Ewing, counsel; Caroline Fiel, clerk; Jeff Shea, professional staff member; and Denise Wilson, minority professional staff member.

Mr. MICA. I would like to call this meeting of the House Subcommittee on the Civil Service to order. The regular procedure in our hearings is that I open with an opening statement and then yield to other Members for their opening statements. We will proceed in that fashion and then begin with our first panel.

This afternoon our hearing will refocus attention on an important issue of military care for our families and retirees. We will examine proposals that will extend the Federal Employees Health Benefits coverage to those with beneficiaries. The delivery of health care to our military personnel is a multi-faceted problem confronting the Department of Defense and the U.S. Congress.

It involves military mission requirements, readiness considerations, recruitment and the retention of a workforce which is fit and ready for duty, and the keeping of promises made for benefits earned, all important responsibilities and obligations. I, for one, am very sensitive to the readiness requirements of our military forces, but I also recognize that we have a very serious responsibility to ensure that those who serve us, or who have served us in the past and also their families, have access to proper care when they need it.

In the area of health care, it now appears that we are failing to keep some of those vital promises which we made to those individuals. Since we do not routinely deal on our subcommittee with military health care issues, let me briefly summarize how we arrived at this particular juncture today.

The Dependents Medical Care Act of 1956 provided medical care for dependents of active duty personnel and for military retirees and their families, and this was to be provided at military facilities on a space-available basis.

By 1966, the demand for health care actually exceeded the capacity, and legislation was passed to create a DOD-sponsored health insurance plan. This program, called the Civilian Health and Medical Program of Uniformed Services, more commonly known as CHAMPUS, generated frequent complaints over its high out-of-pocket costs and the fact that military beneficiaries 65 and older were left out of the system. With ready access to proper care becoming more difficult, in 1993 DOD implemented what is termed TRICARE, a nationwide program organized around existing military treatment facilities which added managed care to existing fee-for-service options.

To date, however, TRICARE has not lived up to expectations, and it is producing largely disappointing results. We will hear about some of that today. We have heard many complaints from persons who live far from military treatment facilities and from senior retirees who not only are ineligible for TRICARE, but have the lowest priority for access to military facility care.

Today, we hear even more complaints and louder complaints about poor access for families of active duty personnel. On a recent congressional visit with some of our military personnel, I met a young sailor on board a Navy ship who vented his frustration to me. He was actually talking about trying to get care for his dependent daughter. He told me that among enlisted personnel TRICARE is ironically referred to in the service as, and I will quote him, "try to get care," and I think we will hear examples of that today.

Our subcommittee jurisdiction extends to the FEHB Program for Federal employees and not to the military health care system. That jurisdiction rests with the Committee on National Security. I have spoken about these problems personally with the chairman of that committee, Mr. Spence, and with the chairman of the Subcommittee on Military Personnel, Mr. Buyer, and I have made a commitment to work with them to come up with a reasonable solution.

With nearly half of this legislative session and this year behind us, we are fast approaching the point where Congress will have to act collectively to correct the persistent deficiencies in our military health care system. Once again, base closures, budget reductions and general downsizing are making DOD's space available approach increasingly ineffective. When it comes to health care, it appears that we are relegating military families and our retirees to second class status. I find this situation deplorable and I find this situation unacceptable, and there is no question that it is sorely in need of reform.

I believe a reasonable alternative is to open the FEHB Program to active duty, dependents, retirees and their dependents. The FEHB Program is the largest employer-sponsored health care program in our Nation, and it provides enrollees with a reliable, comprehensive medical benefits program at a reasonable cost. It is a competition-based program that is working extremely well. Overhead and administrative costs are low, while choices for employees include a broad array of options to meet their specific health care needs. The insurance carriers have been highly successful in containing costs without cutting benefits, and in holding the line on

premiums—all elements that we think that we should share with folks who are now being denied proper coverage.

I want to welcome our witnesses today. We will hear from several distinguished Members of the House who have sponsored legislation to authorize access to the Federal Employees Health Benefits Program, and we will hear from various groups of military beneficiaries.

We will also hear from the National Military Family Association, the Retirement Activities Office at Mountain Home Air Force Base, and two individuals who know all too well the difficulties in gaining access to proper care under the current system. They will relay their particular dealings with the system to the subcommittee today.

We have also asked the Department of Defense to address some of our concerns and the Acting Assistant Secretary for Health Affairs. Hopefully, that Department will provide a response.

I look forward to their testimony, and even more so, I look forward to enactment of some legislation which will address a very dire problem we are facing.

I am pleased now to yield to our distinguished ranking member, the gentleman from Maryland, Mr. Cummings.

Mr.CUMMINGS. As the ranking minority member, I extend a warm welcome to our congressional colleagues and other panelists. Thank you for agreeing to appear in person before our subcommittee and present testimony on military access to the Federal Employees Health Benefits Program.

Today's hearing is important. It has been 2½ years since this subcommittee looked at the issue of improving access to health care for military families via the FEHB Program. Since that time both the House and Senate have held hearings on this matter and many bills have been introduced to address the inability of non-active duty military beneficiaries, especially those 65 over and over, to receive health care benefits.

There are many concerns which need to be addressed in dealing with this issue. The Department of Defense promised to provide free health and dental care to every member of the military. Those 65 years of age and older, who choose military service as a career and put their lives on the line defending this country, are finding that they are not eligible for the military health care system, TRICARE.

Retirees over 65 can obtain military health care only if space is available and after TRICARE enrollees and other active duty members and their dependents receive care. They face high out-of-pocket costs and limited, if any, pharmacy benefits. Military beneficiaries desperate for a solution to the inadequacies of TRICARE, want to be included in the FEHB Program.

Yet the FEHB Program provides voluntary health insurance for over 9 million retirees and their dependents. Program enrollees can choose between 10 to 30 plans available to them in their geographic areas. To differing degrees, FEHB plans cover inpatient and outpatient care, prescription drugs and mental health services, and many other dental care expenses. This plan is considered a model health care system and it would be unfortunate to help one group of beneficiaries and hurt another.

Last November, in a letter to the Secretary of Defense William Cohen, the National Association of Retired Federal Employees expressed concern that absent sufficient safeguards, proposals to broaden participation in the FEHB Program could result in higher premiums, reduced coverage and fewer plan options for other Federal civilians and non-Federal civilians. NARFE suggested that separate risk pools be created for Federal civilian employees and military retirees.

The Office of Personnel Management recommends that any alternative program for military health care be modeled on the Federal health plan, but be an entirely separate parallel program. The FEHB Program should be the exclusive vehicle for health care coverage for a broad class of beneficiaries and be delayed or phased in to permit adequate planning for new populations.

Without a doubt, military retirees and families deserve a quality health care system. We are here today to discuss how best to make that happen. I look forward to the testimony of our witnesses and hope that you will assist us in resolving the many complex questions which surround this matter.

Thank you very much, Mr. Chairman.

Mr. MICA. Thank you, Mr. Cummings.

Now I would like to turn to our first panel this morning, and we have four distinguished Members of Congress, our colleagues on both sides of the aisle who have introduced legislation to remedy the problem that you have heard described in the opening statements today.

I would like to first recognize the gentleman from Florida, Mr. Stearns.

STATEMENTS OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA; HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA; HON. WILLIAM "MAC" THORNBERRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS; AND HON. J.C. WATTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. STEARNS. Thank you for holding this hearing. As Members from Florida, you and I both represent districts with similar demographics, a large seniors population and a significant number of veterans.

As chairman of the VA Health Subcommittee, I hear from veterans and military personnel, both active and retirees, on a regular basis at my town meetings. There is one clarion call that I hear from them repeatedly, and that is: "When I signed up to serve in the military, I was promised health care for life."

The focus of today's hearing concerns the military health care system and how we might change the current system to make health care more accessible to both active duty and retired military.

Under the new TRICARE system, retirees over 65 will no longer be treated by military treatment facilities unless the DOD is able to receive Medicare reimbursement. As DOD's new managed health care program is implemented throughout the country, retirees over 65, those not eligible to enroll in TRICARE—since being Medicare

eligible automatically makes you not eligible for TRICARE—will be forced away from the military treatment facilities and will be forced onto Medicare.

Of the 1.2 million military beneficiaries 65 or older who are eligible for Medicare, approximately 324,000 receive "space available care" in military treatment facilities.

Now, I want to address the FEHB Program as a complement to military health care. This program has been successfully operated over the past 30 years at about one-third of the cost incurred in other private health care insurance programs. Under this program a consumer could opt to buy coverage that would include fee-for-service, HMO, PPO, or a union-sponsored plan similar to the postal workers. In order to ensure that our military have the same choice of plans now available to Members of Congress, Senators and the President and Vice President, and over 10 million Federal workers, I have introduced two bills that would offer our Nation's military and veterans the same basic benefits that you and I have here in Congress.

There are two separate issues that are before us today. The first is how to provide active duty dependents and retirees who live outside a TRICARE prime enrollment area and Medicare eligible beneficiaries who live in the demonstration region access to health care.

My bill, H.R. 2100, would require the Secretary of Defense to conduct a demonstration project to provide covered beneficiaries under the military health care system with the option to enroll in the Federal Employees Health Benefits Program. The bill authorizes a 2-year test, FEHPB test in at least one DOD health care region for all Medicare eligible beneficiaries in test area and active duty dependents and retirees under 65 who live in a test region but outside the TRICARE prime options availability range.

A demonstration project using a broader base of consumers would benefit both the active duty military as well as retired military because it increases the pool by including younger and healthier individuals.

By replacing CHAMPUS with the FEHB Program, the cost of premiums would go down for current beneficiaries and also bring down the cost for retirees because there would be a bigger pool. If we include a cross-section of individuals, premiums would be more likely to decrease. Limiting this option only to retired military would defeat the purpose of the intent since an increase in premiums could be the likely result.

Such a demonstration project will help us to determine Government costs and beneficiary interest before deciding whether to implement this program on a nationwide basis.

Another feature of H.R. 2100 is it allows participants in the demonstration project to establish medical savings accounts. Medical savings accounts would be beneficial because they could be used for co-pays, deductibles, insurance premiums and other out-of-pocket expenses.

Because the need for expanded health care for military retirees is so important, I also introduce my bill to permit Medicare eligible retired members of the Armed Forces and their Medicare eligible dependents to enroll in the Federal Employees Health Benefits Program.

This bill is H.R. 2128. It authorizes FEHBP participation for the 1.3 million Medicare eligible DOD beneficiaries and prohibits concurrent eligibility from military facility care, but the FEHBP disenrollment is irrevocable. Beneficiaries of the FEHBP premium share is the same amount as for similarly situated Federal employees, and a separate military enrollee risk pool would be established. DOD would contribute the remaining amount up to the total premium. It would also require DOD and OPM to study the program each year of its operation.

Mr. Chairman, we will hear from several other Members today about legislation they introduced to address the many problems both active duty and retired personnel must contend with in order to simply access health care. I commend all of them, too.

I have co-sponsored two bills which I think would do a lot to help the common good, which is to ensure quality health care which is both affordable and accessible for all those who have served their country so nobly.

Thank you, Mr. Chairman.

Mr. MICA. Thank you for your testimony.

I would now like to recognize the former ranking member of our subcommittee, the gentleman from Virginia, Mr. Moran.

Mr. MORAN. Thank you very much, Mr. Chairman. I am sure that you are more than happy to have Mr. Cummings, and I bet Mr. Cummings is doing a great job and undoubtedly is more conscientious than I was.

Let me get down to the subject at hand. I thank you and the committee for inviting me to be part of this panel and to highlight the problems with the military medical system. It has serious problems.

As all of you very well know, we have introduced legislation to address those problems. I have introduced legislation that grants Medicare eligible military retirees the option of participating in the FEHBP. It is very similar to H.R. 3012 that I put in last year. It currently has 140 co-sponsors. I have introduced legislation that establishes a test of the Health Care Commitment Act, H.R. 1766, and in this Congress it has 240 co-sponsors. We have been pushing on this, and the Military Coalition has been terrific in supporting it. The companion bill introduced in the Senate has 58 co-sponsors.

The reason that I introduced this bill is because I, as well as others, am deeply concerned that the military retirees, particularly once they become eligible for Medicare, are being denied access to quality accessible health care. Medicare eligible retirees are denied access to CHAMPUS. As soon as they need it, they are not eligible for it. They are prohibited from participating in TRICARE and they are effectively shut out of the military medical treatment facilities because they are put last in the waiting line for receiving any kind of health care.

So in effect we have created a system where military retirees, once they reach the point in life where they need health care the most, are given the least from their former employer. That does not happen in the private sector and it does not happen with civilian retirees.

The fundamental problem of providing health care for military retirees and their dependents lies at the root of the DOD medical

treatment policy. The first goal of DOD is wartime readiness. That is an appropriate goal. It requires that the Department train physicians for wartime and ensures that everyone who serves our country is healthy.

Ancillary to that fundamental mission is the treatment of military retirees. They are not going to go into battle so they do not count as much in terms of the fundamental objective of DOD. So when the DOD decides how to cut back on services to save money, they turn to their ancillary functions to reduce costs. A primary obligation is not providing health care for military retirees. So the effect of this policy is that military retirees, particularly those who are eligible for Medicare, are being squeezed by present and future budget constraints and it is only going to get worse because there is an institutional preference against them.

On the other hand, the civilian retirees, who also served their Government as a career, are given the chance to participate in the same health insurance program that they enjoyed during active service, and almost all of them seize that opportunity.

That participation continues even after the Federal civilian retiree has become eligible for Medicare. In fact, most retirees find that their benefits improve substantially once they become eligible for Medicare. There are no waiting lists. There are no situations where beneficiaries were promised free subscription drugs only to find that it doesn't extend to the drugs they actually need. There is only quality health insurance coverage which is comprehensive with an annual option to change plans and that is because of the wraparound. Medicare is a first payer and FEHBP is a wraparound, so they get better service and it is less expensive. It is a great deal.

The reason Federal retirees have all these options is because they were promised health care as part of their basic compensation package. The mission of FEHBP is focused on the beneficiary and not on the mission of the agency that they work for. That is in contrast to military retirees, who think that they were promised health care. When they were recruited, the recruitment brochures say free quality health care for the rest of their lives. Lifetime health care.

We had a hearing on this and we asked the representatives from DOD and they said, "well, you know, this is recruitment tactic." It is not a legal obligation. That is the problem.

So after working on this issue for about 3 years now, I think that is our basic problem and that is why we need legislation. We need legislation, first of all, to make health care part of the compensation package. It shouldn't be an ancillary requirement. It really needs to be a fundamental benefit for servicing our country. That is basically what needs to be done. But we can't do that this year. I don't know when it is going to be done, and in the meantime the people who thought that they were getting free quality lifetime health care should not be denied it because we are trying to save money within the defense budget.

So the reason that I have introduced this legislation is to give Medicare eligible retirees the same option that Federal civilian retirees have. It does establish separate risk pools so that Federal civilian retirees are not going to have to pay more because of a new

pool that is coming in. They don't cross-subsidize one another. I think that is terribly important. It is an accounting mechanism that will ensure that both groups are large enough pools, but one doesn't harm the premium cost for another.

It also ensures that gold star widows are covered, and it provides better reporting requirements. It does a lot of good things. I am not going to bore you with all of them, but I have some concerns about H.R. 76, and alternative versions of the bills I have introduced, and I should share those with you.

Enrollment in the FEHB Program is geographically based, while Blue Cross and other fee-for-service programs are nationwide. The majority of the plans are limited to certain geographic areas and set their premiums based on a projection of participation in that area. Allowing military retirees and their dependents to participate in a first come, first served basis can easily create a situation where participants are disbursed across the country and few people from any one geographic area participate. This will not allow plans to adequately project the number of participants and set their premiums accordingly. It is important because every FEHB proposal establishes separate risk pools.

Rather than go through the expense of developing a premium structure for an indeterminate number of participants, I feel that a number of plans simply will choose not to participate. This would create inequities between the FEHBP for Federal beneficiaries and military retirees. You will have premiums that are substantially out of whack between the two programs. That is one concern.

The second is allowing all military retirees to participate. I don't think that will work. Premiums in FEHB are based on an assessment of the cost of the risk pool. Medicare eligibles are much cheaper for the health insurer. The health insurer pays about 90 cents for every dollar in health insurance premiums for those on Medicare, because Medicare is the primary payer.

Those who are 45 to 65 and not eligible for Medicare cost the insurer $2.50 for every dollar in premiums. Because Medicare is not the first payer, the insurer is paying two and a half times as much cost. For that reason, when retirees under 65 participate, it is going to drive up the premiums for everyone else. Because many of these risk pools are going to be smaller compared to the 9 million beneficiaries of FEHBP, including non-Medicare eligible retirees some of those premiums are going to be unaffordable for the people who need it the most.

Last, requiring participants to sign up for 3 years is not an acceptable option. FEHBP is successful because it allows great choice among plans and provides coverage even if a beneficiary moves from one area. If a beneficiary moves out of an area covered by his HMO, he should be free to leave FEHBP if he chooses. The alternative does not allow that. The 3-year enrollment condition is not placed on civilian beneficiaries and should not be placed on military beneficiaries. It is not like a retirement plan where the beneficiaries should be vested. Premiums are based on each year's participants. A better way is to ensure that beneficiaries don't game the system by signing up only when they need coverage, is to make the decision to leave FEHBP irrevocable.

I have one other point, the timetable for implementation. H.R. 3613 requires the Secretary to begin to offer FEHBP benefits within 6 months of enactment, subtracting the 90-day open season provided in the legislation. This would require DOD and OPM to develop the FEHBP option within 3 months of enactment and establish the premium rates for the new beneficiaries. Assuming the bill would be enacted as part of the DOD Authorization Act, this provision would require the insurance companies to prepare and submit their rates between October of this year and February of next year. I don't think that is realistic. The shortened timetable as compared to the scheduled FEHB timetables is going to cause many plans who offer insurance to civilians to choose not to participate in the military retiree FEHBP plan. Again, this would cause discrepancies between the two and I think we need to ensure that there aren't such discrepancies.

These are just a few of the concerns I have with H.R. 3613, but I strongly support the interest in the FEHBP option, and I know we can be successful in enacting an FEHBP proposal this year if we can work together and consolidate our bills.

I do very much appreciate your holding the hearing and for the intense interest that you have had in this and thank you for your leadership, Mr. Mica, and thank you, Mr. Cummings, for yours as well.

[The prepared statement of Hon. James P. Moran follows:]

Statement of Representative James P. Moran
Hearing on FEHBP as an Alternative to Military Health Care
Subcommittee on Civil Service
April 28, 1998

Mr. Chairman:

Thank you for inviting me to participate in this hearing and continuing your efforts to highlight problems with the Military Medical system.

As you know, I have introduced legislation granting Medicare eligible military retirees the option of participating in the Federal Employees Health Benefits Program. This legislation is similar to H.R. 3012 introduced in the 104th Congress and currently has more than 140 co-sponsors. My legislation establishing a test of the Health Care Commitment Act, H.R. 1766, currently has more than 240 co-sponsors. The companion bill introduced in the Senate, has 58 co-sponsors.

I introduced the Health Care Commitment Act because I am deeply concerned that military retirees, particularly once they become eligible for Medicare, are being denied access to health care. Medicare-eligible retirees are denied access to CHAMPUS. They are prohibited from participating in TRICARE. They are also effectively shut out of military medical treatment facilities because they are placed last on the priority list for receiving care. In effect, we have created a system where military retirees, once they reach the point in life where they need health care the most, are given the least from their former employer. This does not happen in the private sector and does not happen to federal civilian retirees.

The fundamental problem of providing health care for military retirees and their dependents lies at the root of the Department of Defense medical treatment operations. The first goal of the Department of Defense is wartime readiness. This is a proper goal and requires that the Department train physicians for wartime and ensure that the men and women who serve our country are healthy. Ancillary to these objectives is the treatment of military retirees. So it naturally follows that when the Department must cut back on services because of budget constraints, they are more likely to cut the ancillary functions than reduce their primary obligations. The practical effect of this policy is that military retirees, particularly those who are Medicare-eligible, are continuing to feel squeezed by present and future budget constraints and by an institutional preference against them.

On the other hand are federal retirees. They too have served their government as a career and sacrificed themselves for the good of us all. Unlike their counterparts who served in the military, federal employees, upon retirement, are given the chance to participate in the same health insurance program they enjoyed during active service. This participation continues even after the federal retiree has become eligible for Medicare. In fact, many retirees find that their benefits improve once they become Medicare-eligible. There are no waiting lists. There are no situations where beneficiaries were promised free prescription drugs only to find that this does not extend to the drugs they actually need. There is only quality health insurance coverage with an annual option to change plans.

The reason federal retirees have more and better health care options is simple. Federal employees are promised health care as part of their basic compensation package. The sole mission of the Federal Employee Health Benefits Program is to serve the beneficiary and ensure that the health coverage is sufficient. In contrast, while military retirees believe they were promised health care as part of their compensation package, they are finding they were not. Instead, the recruitment brochures and promises only mentioned that a system does exist through which they could receive health care if available.

After working on this issue and following it closely for the past three years, I have come to believe that this is the central point. Do we offer health care coverage to our military members and retirees as part of their compensation package or not? Every major employer in this country, including the federal government itself, provides health care coverage for its employees. This is as fundamental as retirement benefits and pay and just as necessary to recruit and retain talented employees. If the Department of Defense is going to offer health care as part of its compensation package, it should say out front what is covered and who is covered. It should allow its recruits to make their decisions based on complete information.

While the Department considers this larger philosophical question, Congress should act to remedy the most egregious shortfall in the current Department of Defense health care system. This is the coverage provided for Medicare-eligible retirees. I introduced the Health Care Commitment Act on the first day of the 105th Congress to ensure that Medicare-eligible military retirees and their dependents are provided access to quality health care. This legislation simply gives Medicare-eligible retirees the option of joining the FEHBP. It also establishes separate risk pools to ensure that military retirees and current FEHBP beneficiaries do not cross-subsidize one another. This involves only an accounting effort and will not affect the quality of coverage for either group.

I am currently working on a modification of the Demonstration project to offer as an amendment to the Defense Authorization. This new amendment will differ from H.R. 1766 in that it will remove the demonstration components of H.R. 1766 and will broaden the number of people offered access to the Federal Employees Health Benefits Program. The bill also ensures that "Gold Star Widows"are covered and provides better reporting requirements.

I have reviewed a number of alternative versions of H.R. 76 and H.R. 1766. While I do support the efforts to make this option a reality, I have some concerns about the approaches taken by alternative bills. In particular, I have the following concerns:

1. Participation through "first come first served" -- As you know, the Federal Employees Health Benefits Program is geographically based. While Blue Cross and other fee for service programs are nationwide, the majority of plans are limited to certain geographic areas and set their premiums based on a projection of participation in that area. Allowing military retirees and their dependents to participate in a first come-first serve basis can easily create a situation where participants are disbursed across the country and few people from anyone geographic area participate. This will not allow plans to adequately project the number of participants and set their premiums accordingly. . This is important

because every FEHBP proposal establishes separate risk pools. Rather than go through the expense of developing a premium structure for an indeterminate number of participants, I fear a number of plans simply will choose not to participate. This would create inequities between the FEHBP for federal beneficiaries and military retirees.

2. Allowing all military retirees to participate. As you know, premiums in the FEHBP are based on an assessment of the costs of the risk pool. Medicare-eligibles are cheaper to the insurer, about $.90 for every $1 paid in premiums, because Medicare is the primary payer. Those who are age 45 - 65 are most expensive, up to $2.50 for every $1 in premiums because they are beginning to have health problems and there is no 1st payer. Because these risks pools will be relatively small, compared to the more than 9 million beneficiaries in the FEHBP, the inclusion of non-Medicare eligible retirees can drive the premium costs much higher than the civilian FEHBP. This will make the FEHBP option unaffordable for those Medicare-eligible retirees who need it most.

3. Requiring participants to sign up for 3 years. This is an unacceptable option. The FEHBP is successful because it allows great choice among plans and provides coverage even if a beneficiary moves from one area to another. If a beneficiary moves out of an area covered by his HMO, he should be free to quit the FEHBP is he chooses. The three year enrollment condition is not placed on civilian beneficiaries and should not be placed on military beneficiaries. This is not like a retirement plan where the beneficiary should be vested. Premiums are based on each year's participants. A better way to ensure that beneficiaries do not game the system by signing up only when they need coverage is to make the decision to leave the FEHBP irrevocable.

4. Implementation: H.R. 3613 requires the Secretary to begin to offer FEHBP benefits within 6 months of enactment. Subtracting the 90 day open season provided in the legislation, this would require the Department of Defense and OPM to develop the FEHBP option within 90 days of enactment and establish the premium rates for the new beneficiaries. Assuming the bill would be enacted as part of the DoD Authorization Act, this would require the insurance companies to prepare and submit their rates between October 1, 1998 and February 1, 1999. I do not believe this is realistic and I believe the shortened timetable, as compared to the scheduled FEHBP timetables, will cause many plans who offer insurance to civilians FEHBP beneficiaries to choose not to participate in the military retiree FEHBP plan. Again, this would cause discrepancy between the two and I think we should act to ensure their are no such discrepancies.

These are just a few of the concerns I have with H.R. 3613. I do support, however, the strong interest in the FEHBP option and I know we can be successful in enacting a FEHBP proposal this year if we work together.

Thank you again for holding this hearing and inviting me to participate.

Mr. MICA. Thank you for your testimony, Mr. Moran.

I would like to recognize Mr. Thornberry, the Representative from Texas.

Mr. THORNBERRY. I too appreciate the invitation to be before you today and appreciate this committee and subcommittee's interest in this issue. One of the things that those of us on the National Security Committee have come to understand is that we can't solve this problem on our own. Because of the jurisdictional issues, it will take a number of committees working together to do so. I have submitted a formal statement for the record, but I will just make a few comments.

Mr. MICA. Without objection, that will be made a part of the record.

Mr. THORNBERRY. Thank you. I certainly have been interested in this issue since I first ran for office. It doesn't take a lot of investigation to find that the Government made a promise, and whether it is a legally binding promise or not, folks believed in the promise and it is my view that we ought to keep the promise.

I spent the last Congress on the Personnel Subcommittee of the National Security Committee, trying to listen and learn about all of the different permeations of this issue. During that time Medicare subvention was the answer that was pushed first and foremost as a solution to this problem. But as I look at the way that applies to my district, I see that it is not enough. Let me just outline for you the situations that I find in my one congressional district which have led to the legislation which I have introduced.

I have one primary city with a major Air Force base and a hospital at the base. Military retirees right around the base cannot get into that hospital. It is not so much a physical limitation as it is a staffing problem because we have had over the past few years medical personnel sent off to Bosnia and Haiti and other places, so there are not the medical folks there to treat the retired military, so they don't get seen.

In another part of my district, I have an Air Force base that was closed in the last round of BRAC. Obviously those retirees in that area have been used to going to that Air Force base and that hospital and now that that is closed they don't have any place to go.

I have another city in my district which has a major VA facility, but it doesn't have a military treatment facility for several hundred miles. Another part of my district is in the Dallas-Fort Worth Metropolitan Area. No close-by medical treatment facilities, but obviously lots of health care options. Then I have some folks out in rural areas that are an hour or more from any sort of doctor or nurse practitioner, and certainly much further away from any sort of hospital or major medical facility.

So as I look at the different situations that exist in my one district, it became apparent to me that no one answer is going to fix all of those problems. So I tried to work with folks on the Military Coalition Health Care Committee to come up with a series of options that would try to cover people in the different situations they find themselves in across the country as the military downsizes and as we have fewer and fewer doctors in the military.

That is where I came up with and introduced H.R. 1456, which has several options. It includes Medicare subvention. It includes al-

lowing Medicare eligible retirees to re-enroll in TRICARE. It improves the benefits in CHAMPUS and TRICARE standard. It tries to encourage and make easier, including the VA facilities as part of the military retiree health care options, and it includes FEHBP as an option to try to cover those bases.

It does not—it still, putting all those options together, and it still does not keep our promise of providing lifetime health care for free or at no cost, but I think together it comes as close as we can reasonably come in this Congress. Of course I understand that that bill is not going to pass this Congress, and as a consequence I have joined with Mr. Watts and yourself, Mr. Chairman, in H.R. 3613, which is an FEHBP pilot program, to at least put another step of this layered approach of options out there and move it. We have a Medicare subvention pilot program which is going. We have a FEHBP pilot program going. At least we seem to be making some progress, and I think that is important.

Finally, Mr. Chairman, I make this comment. It is very important for the Government to do what the Government said it was going to do, but we should not ever underestimate how important it is for us to keep our promise for those young people that are in the military trying to decide whether they are going to stay in the military.

This past weekend I worked in my district on the Christmas in April project with young airmen from Sheppard Air Force Base, as I have done for several years in the past. You get to talking with them about whether they are going to stay in the military, what considerations they are looking at, and health care is always in the top three. Whether the government keeps its promise is always near the top of their mind, and I don't think any of us ought to underestimate the importance of this issue in making sure we get and keep the top quality people that are going to be necessary for this country's security in the future.

So again I appreciate your interest and efforts and I will certainly do all I can to come as close as we possibly can to keeping our promise.

[The prepared statement of Hon. William "Mac" Thornberry follows:]

MAC THORNBERRY
THE DISTRICT
TEXAS

Congress of the United States
House of Representatives

COMMITTEE ON
NATIONAL SECURITY
COMMITTEE ON
RESOURCES
JOINT ECONOMIC
COMMITTEE

Statement of Representative Mac Thornberry

Committee on Government Reform and Oversight, Subcommittee on Civil Service

April 28, 1998

I would first like to thank Chairman Mica, Ranking Member Cummings, Vice-Chairman Pappas and Members of the Committee on Government Reform and Oversight's Civil Service Subcommittee for the opportunity to come and testify today regarding the health care crisis facing military retirees and the legislation I introduced to address the problem, the Uniformed Services Retiree and Dependents Health Care Availability Act (H.R. 1456).

For over 40 years, the federal government told young Americans that if they served honorably throughout their career in our country's armed forces, the government would provide health care for the rest of their life. Until recently, this was a commitment the government largely kept. But with the number of military hospitals and doctors shrinking, and the number of military retirees and their families continuing to rise, the government now says there's not enough space, personnel, or money to handle the demand.

The Department of Defense (DoD) lawyers argue the health care promise is not a legally enforceable promise. Perhaps they are legally correct. But the DoD knew that young men and women relied upon that promise in choosing to enlist or reenlist, even as late as the 1990s. Even if the government does not have a legal obligation to provide the promised health care, we no doubt have a moral obligation.

In my opinion, there are two independently sufficient reasons why we must help the DoD keep its health care promise. The first reason, as I just referred to, is the moral obligation to our old warriors. But the second and equally sufficient reason is because keeping promises on benefits is critical to our ability to recruit and retain our nation's best and brightest youth to be

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our future warriors.

We all understand that times have changed since today's retirees signed up for WWII. But, the fact remains that the federal government gave its word to our country's service men and women and now they must keep it. The legislation I've introduced is not perfect -- it does not provide completely free health care to all retirees as they were promised. But it does come closer than any other proposal in Congress to fulfilling the federal governments commitment to provide lifelong health care benefits to our Nation's military retirees and their families.

I believe H.R. 1456 is a step in the right direction, and something which will not only address many of the concerns retirees have with the current system, but also legislation that will help keep top quality people from opting out of military service. As I travel to military installations around the country, I always stop to ask today's members of the armed services what are the key issues that will help us get and keep top quality, well trained individuals in the military. And, every time I ask our young men and women that same question, health care is right at the top of their list.

The Uniformed Services Retiree and Dependents Health Care Availability Act of 1997 *(HR 1456)* will expand the health care options of military retirees and their families by accomplishing four main objectives:

- ***Allow Medicare to Reimburse the Department of Defense (DOD) for Care it Provides Retirees.*** As it stands now, when military retirees reach the age of 65 they are no longer eligible to receive military medical care and must switch their coverage to Medicare. My legislation would allow the DOD to receive reimbursement from Medicare, thereby allowing the Department of Defense to provide expanded care to retirees over the age of 65. Commonly referred to as Medicare Subvention.

- ***Give Medicare-eligible Military Retirees the Option of Enrolling in TRICARE Prime.*** As you know, TRICARE Prime is the Health Maintenance Organization (HMO) option

which provides retirees with health care through military hospitals. Currently, retirees over the age of 65 are not eligible to enroll in the program. I believe we should extend eligibility to these individuals and allow them to enroll in the program. My legislation would allow retirees over 65 the opportunity to continue to enroll in Tricare Prime.

- ***Provide Medicare-eligible Retirees the Option of Participating in the Federal Employee Health Benefit Plan (FEHBP).*** As it stands now, all Medicare-eligible military retirees cannot receive care in military treatment facilities because there is simply not enough space, doctors and equipment. With the continuing downsizing of the military and the number of retirees continuing to grow, this problem will only get worse in the future. To address this problem, and to provide an option to those who do not live near a military hospital, I included a provision in my bill that would give retirees the option of enrolling in the FEHBP, currently available only to federal employees.

- ***Improve CHAMPUS and TRICARE Standard Benefits to a Level Comparable to the FEHBP.*** CHAMPUS is the fee-for-service benefit plan which provides health care coverage in non-military facilities to both active duty personnel and retirees under the age of 65. My legislation would correct many of the problems in the CHAMPUS and TRICARE Standard programs, or give under 65 retirees the option of participating in the FEHBP if they so choose.

I believe, if implemented, these four objectives would achieve my goal of providing a reasonable health care option to every military retiree, regardless of the area of the country in which they lived.

Since only 35 percent of our Nation's retirees currently live in an area served by a military hospital, allowing Medicare to reimburse the Defense Department for care received at military facilities would fail to address the needs of well over half the retirees in the United States. Likewise, allowing military retirees to enroll in the Federal Employee Health Benefit Plan is an attractive option for a retiree living outside a catchment area, but not to one who lives

closer to a military hospital and wishes to obtain his or her medical care there.

Another consideration I had in developing this plan was the limits of the military health care system, itself. The TRICARE Prime program isn't capable of handling the health care needs of every retiree and their family, as well as the active duty personnel the program currently serves. There have also been a number of difficulties in the program, including a problem with retaining physicians, cuts in funding, administrative restrictions, and space available care not being provided. So to put all our eggs in this one basket at this point in time would be a foolish thing to do. I believe my multi-layered approach will give retirees better choices and greater access to obtain the kind of health care they need, deserve, and were promised.

However, like everyone here, I am a realist and familiar with the pace it takes for things to get accomplished here in Washington. And, I am a strong advocate for taking steps toward allowing our retirees to enroll in FEHBP and the Medicare Subvention program.

That being said, let me comment briefly on the Federal Employee Health Benefit Plan. As you know, Mr. Chairman, we recently introduced the Military Health Care Fairness Act along with Mr. Watts and others that will provide military beneficiaries nationwide the option of enrolling in FEHBP. I am particularly concerned about the over-65 retirees that are left only with Medicare and space-available care for their health care needs and nothing else. The Department of Defense estimates about 25% of the 1.2 million Medicare-eligible beneficiaries are currently reliant on military hospitals for a large majority of their health care. With space available care existing only in theory, a large chunk of Medicare eligible retirees are not receiving medical care. I have questioned the Assistant Secretary of Defense for Health Affairs about this issue a number of times, most recently before the House National Security Committee in February. The answers I received only reaffirmed my concern that retirees are not receiving the type and quality of medical care they deserve.

Yet year in and year out, Congress appropriates some $4 billion annually for FEHBP for Federal civilian retirees, including DoD civilian personnel, while the DoD is closing military

hospitals, downgrading other hospitals to clinics, and disengaging its military retirees from health care to save money.

While some have argued that FEHBP should only be opened to Medicare-eligibles (65 and over), I believe it is important to allow all beneficiaries the option of enrolling in the nationwide Federal Employee Health Benefit Plan. This will allow those individuals who do not live close to a military hospital the option of enrolling in the same health care option as Members of Congress, Congressional staff, and other federal employees.

While I pushed very hard for the Medicare Subvention legislation that established test programs throughout the country last year and have recently sponsored FEHBP legislation with you, Mr. Chairman, I believe it is important that we not stop there.

In considering H.R. 1456 and all other military health care bills, I think it's important for everyone to remember that this is an issue that goes to the very core of our ability to provide for the national defense. Concern over future health care benefits is one of the most important issues for servicemen and women when it comes time for recruiting or reenlistment. In order to get and keep the high quality personnel that epitomize the U.S. military, we must provide the kind of care our personnel require and deserve.

Mr. MICA. I thank you for your testimony, and I yield now to the gentleman from Oklahoma, Mr. Watts.

Mr. WATTS. Thank you, Mr. Chairman, and I would like to congratulate you, Mr. Mica, and the ranking member, Mr. Cummings, and Vice Chairman Pappas for holding today's hearing on the critical topics of military retiree health care and the Federal Employees Health Benefits Program.

This is an issue of great importance that has languished for too long on the agendas of Congress and the Department of Defense, and it is a credit to all of you and the members of this subcommittee that you brought this issue to the light of day in an attempt to improve the delivery of health care to military retirees and their dependents and the active duty military.

Mr. Chairman, for the sake of time, Mr. Thornberry and I introduced H.R. 3613, the Military Health Care Fairness Act, together with you, Mr. Inglis, and Mr. Cunningham, and I hope to bring the bill to the Personnel Subcommittee of the National Security Committee for consideration this Thursday.

In brief, H.R. 3613 would provide military retirees with the option of selecting FEHBP for their health care coverage through the use of cost caps, a 5-year demonstration period and a limitation to Medicare eligible retirees in the first 2 years of the program. This legislation will keep costs low while providing comprehensive coverage for the majority of military retirees who would seek this option.

H.R. 3613, you all have taken a look at that and, Mr. Chairman, anything that I say is going to be redundant. We all see the need to fix a serious problem. We have people, retirees with no place to go, problems with TRICARE, space availability problems, retention problems, in part due to the military health care problems that we have experienced. We have talked about this thing for many years now, and I think we all agree that it is time to fix it and come up with some conclusions or some solutions. For the sake of time I will submit my statement in its entirety for the record. Thank you.

[The prepared statement of Hon. J.C. Watts follows:]

April 28, 1998

Statement of Congressman J.C. Watts, Jr.
before the
Committee on Government Reform and Oversight, Subcommittee on Civil Service

I would like to congratulate Chairman Mica, Ranking Member Cummings, and Vice-Chairman Pappas for holding today's hearing on the critical topics of military retiree health care and the Federal Employees Health Benefits Program. This is an issue of great importance that has languished for too long on the agendas of Congress and the Department of Defense. It is a credit to all of you, and the members of this subcommittee, that you have brought this issue into the light of day in an attempt to improve the delivery of health care to our military retirees, their dependents, and the active-duty military.

The essence of any discussion on this topic is the broken promise of free, lifetime health care that was made by our government to millions of people who served in the armed forces. These people were promised that if they served 20 years or more in the military, they would receive free health care for life. Everyone here knows that that promise was broken and has not been restored.

Today, we face a situation wherein thousands of military retirees are forced to scramble for adequate health care for themselves and their dependents. They must make do with the TRICARE system, space available care in a rapidly diminishing number of military hospitals or, if they are at least 65 years old, they must use the Medicare system. Those who live far from military treatment facilities or hospitals that accept TRICARE often purchase private medical insurance or simply remain uncovered by affordable, convenient health care. This is wrong.

My colleagues on this panel have spoken eloquently about the need to provide health care to military retirees. They have demonstrated conclusively that military retirees have not been provided the health care that they were promised. I would like, however, to take a moment to explain why military health care impacts the men in women who serve in the armed forces today and those who are considering military service. As you will see, the relationship is direct.

Men and women join the armed forces for a wide variety of reasons, but the two most important are patriotism and the opportunity to enjoy a modest package of benefits at retirement. That current and future generations will join the military out of a sense of duty to their country is a given. But, like their parents and grandparents before them, they should do so secure in the knowledge that if they serve 20 years in the military, they will be provided access to reliable, affordable, convenient health care. In a booming economy such as we enjoy today, we cannot permit further erosion of the benefits package that comes with military service. Indeed, the erosion must be reversed. The junior officers and enlisted men and women, as well as young people considering military service are watching us right now. And, they are making decisions about whether a career of hard work and sacrifice in the military might be a worthwhile endeavor. In this way, the very future of the military hangs on important benefits such as health care.

It is for these reasons that I introduced HR 1356, the Military Health Care Justice Act, and its less costly companion, HR 3613, the Military Health Care Fairness Act, together with Chairman Mica, Mr. Thornberry, Mr. Inglis, and Mr. Cunningham,. I hope to bring the latter bill to the Personnel Subcommittee of the National Security Committee for consideration on Thursday.

In brief, HR 3613 would provide military retirees with the option of selecting FEHBP for their health care coverage. Through the use of cost caps, a five year demonstration period, and a limitation to Medicare-eligible retirees in the first two years of the program, this legislation will keep costs low while providing comprehensive coverage for the majority of military retirees who would seek this option.

Further, I believe that most of these people will be located in areas distant from a military treatment facility catchment zone and, thus, there will be little or no impact on the MTFs. In fact, I believe that the problem of space available care would be alleviated by removing many people from the system. Medical readiness would not be measurably impacted given the current overcrowding of our facilities and the reduced medical mission requirement of the military.

Finally, like the other FEHBP bills described today, HR 3613 would help restore the broken promise of lifetime, free health care made by the government to so many men and women in the armed forces. It won't be free, and it won't cover every military retiree in need of health care. But it will relieve the problems of adequate access to health care suffered by many. Significantly, it would do so just

six months after the bill is enacted. That means that military retirees could begin to select this option as early as next year, thereby sending a concrete expression of support to our military retirees, those currently on active duty considering a career in the military, and those contemplating military service.

Mr. Chairman, too often we overlook the important contribution made by the men and women who serve in the armed forces. But when American interests are on the line in some distant, inhospitable land, we still look to those in uniform to carry out dangerous missions. We are fortunate that there always will be people who will "be there" for America in time of war, or even, minor conflict. However, we must ask ourselves if we will be able to sustain a strong, professional military with adequate numbers of career officers and non-commissioned officers if we don't provide them with some small incentives like adequate health care in their retirement years.

In many ways, the military is similar to a national insurance policy. We don't always need it and we may grumble about the bill, but we are glad that it exists when trouble lurks nearby. In that light, the provision of FEHBP for military retirees would be one more kind of national insurance policy. An insurance policy to give peace of mind to those will defend the nation.

Thank you, Mr. Chairman.

Mr. MICA. Members, first I want to commend each and every one of you on your leadership on the issue. The bills have some minor differences, and I see that there is now a consensus to try to go to a demonstration project or a limited project.

Mr. Moran, do you agree with that approach now?

Mr. MORAN. I do, Mr. Mica. Budget-wise, there is no way that we are going to get the money for a full-fledged implementation program, and it probably makes sense to test it out so we will have a better sense of what it is going to cost the Federal Government and how it best works.

Mr. MICA. If we did a demonstration project, if we made eligible the dependents of active duty personnel, you will favor that, Mr. Watts?

Mr. WATTS. I would favor that surely not—no, I would not be opposed to that.

Mr. MICA. Mr. Thornberry?

Mr. THORNBERRY. I agree.

Mr. MICA. Mr. Moran?

Mr. MORAN. I think dependents should be included the same as they are with FEHBP. But I think it is a mistake to include 45–65 at this stage because the cost is substantially more. It is two and a half times greater to include that age population versus the Medicare eligible.

And I explained the reasons. Once they become eligible for Medicare, that is the first payer and so it becomes cheap for the other health care.

Mr. MICA. One of the objections to doing it that has been stated by the administration, and also by the Appropriations Committee, is the cost.

Mr. Moran, do you think in a year when we have a potential for a small surplus that this should be a priority?

Mr. MORAN. Actually, I do think that this should be a priority. I think the demonstration program is relatively inexpensive. The fact is that military retirees are getting turned away. They are going to medical military treatment facilities and they are—and they are not able to receive care, and so it is not as though we are offering something new that people are not accustomed to. They are accustomed to going to military treatment facilities and they are accustomed to being served at least on a first come, first served basis. They are not getting it. They are put to the end of the line.

That is why I think there is a certain amount of urgency to this, and it is only a test program so it is going to be more years before we can implement it nationwide. We at least need to have some facts at our disposal to determine the scope, the financing and the logistics of implementing a full scale program, so I think we need to start immediately.

Mr. MICA. What about the issue of cost, Mr. Watts?

Mr. WATTS. I think there is a more central issue here than money. Any time we do anything around this place I think we always have to be conscious of the cost, but fairness to the Nation's military retirees is the most important element to be considered here. However, to contain costs in H.R. 3613 we put some cost caps starting at $100 million in the 1st year escalating to $500 million in the 5th year and, considering the budget surplus that is being

proposed, I think that is a fairly reasonable cost. And compared to what DOD spends on most items in 1998 America, this cost is relatively reasonable.

Mr. MICA. Mr. Thornberry, do you have any comments?

Mr. THORNBERRY. Mr. Chairman, just a couple of things. I think it is a priority and we have to find a way to pay for it. If Mr. Watts is successful in getting it added to the National Security authorization bill, we have to find offsets for it. But it seems to me that we need to do it regardless because of the cost of retention and other reasons that I mentioned.

I think an advantage of H.R. 3613 is it is a nationwide pilot program. One of the concerns that I have had in the past when we talk about Medicare subvention is that it is entered into in too small a locale. It is not a true test project in terms of getting a real feel of what the costs are going to be when applied nationwide. This is a nationwide test and I think that may help us get better numbers and a better feel for the kind of interest that we would find among retired military folks throughout the country.

Mr. MICA. Finally, I think we need to move forward on this. We are trying to push it forward by holding the hearing today and focusing more attention on the problem.

Working within the system as much as we can, one of the things that we may do is try to circulate a letter starting with all of the authors of the legislation, perhaps if we can agree on Mr. Watts' legislation as the vehicle to the leadership, perhaps we can do it from both sides and see if we can't get this moving.

The alternative is a discharge petition and as one of the malcontents who instituted a great procedure which sometimes comes back to haunt us, I haven't considered that yet as an option, but as we get further down the pike and we run out of time, that is another option.

But in the immediate future trying to work with leadership and not ruffling too many feathers, I think we should get all of the prime sponsors of the legislation to join together and respectfully request action on this from leadership.

Do you all have any problem with that?

We will do it then.

Mr. Cummings, you are recognized. I don't have any further questions. Mr. Pappas has left us. I thank each of you for joining us. I think we will proceed in that fashion. We will try to get something out in the next 48 hours if we can, and maybe we can ask some of the co-sponsors of our legislation. I don't see any other way to move it forward unless we bring it in some cohesive or joint fashion to the attention of leadership, but I thank you for your testimony today and for your leadership on this important issue in the past. We will dismiss this panel. Thank you.

Our next panel is Sydney Tally Hickey, associate director, government relations, National Military Family Association; Dr. Barbara Glacel, Fort Hood, TX; Boyd Simmons of San Antonio, TX; and Hal Franck, Retirement Activities Office of the Mountain Home Air Force Base.

This is an investigation and oversight panel of Congress. The non-congressional witnesses we do swear in, so if you can please stand and raise your right hands?

[Witnesses sworn.]

Mr. MICA. The witnesses have answered in the affirmative and we are pleased to welcome the second panel this afternoon.

It is also customary, I don't think that any of you have testified before, to try to limit your remarks to 5 minutes. We will be glad to enter into the record any lengthy statements, but we would like you to orally summarize the contents of your remarks. And again, we will put lengthy statements in the record.

The first witness I would like to recognize is Sydney Tally Hickey, associate director of government relations of the National Military Family Association.

STATEMENTS OF SYDNEY TALLY HICKEY, ASSOCIATE DIRECTOR, GOVERNMENT RELATIONS, NATIONAL MILITARY FAMILY ASSOCIATION; BARBARA GLACEL, FORT HOOD, TX; BOYD SIMMONS, SAN ANTONIO, TX; AND HAL FRANCK, RETIREMENT ACTIVITIES OFFICE, MOUNTAIN HOME AIR FORCE BASE

Ms. HICKEY. Mr. Chairman, Mr. Cummings, thank you. NMFA is grateful to you for your strong interest in the health care of military families and for allowing us to present our views this afternoon. Thank you for allowing our testimony to be submitted for the record, and I will summarize it briefly.

As you have outlined, Mr. Chairman, several changes have occurred in the military health care system over the past 50 years. Each change has been based on the needs of the system, not the needs of the beneficiaries. A constant in the system has been that it delivers care, it does not provide a health care benefit nor a health care insurance plan.

In the last decade, a smaller uniformed medical force and budget constraints combined with the steady beneficiary population caused the Department of Defense to explore other options for the delivery of health care. A variety of demonstration programs were tried in the late 1980's and early 1990's. In 1993, TRICARE was designed to go with the administration's proposed national health care reform.

Since national health care reform did not come to fruition, TRICARE is essentially a spoke without a wheel. DOD has tried issuing hundreds of change orders to its TRICARE contracts and asking for legislative modifications on a yearly basis to turn the spoke into a wheel.

In actual fact, it has just added spokes, and spokes of varying lengths. Rather than the uniform benefit DOD promised when it introduced TRICARE, the benefit keeps getting more un-uniform as each new change is made.

Dual Medicare military eligibles are locked out of TRICARE. Their space availability in military hospitals is drying up as these hospitals are primarily resourced based on TRICARE prime enrollment.

The subvention demonstration is not yet implemented, although it was authorized to be implemented by the first of January. Even if the program were fully implemented, it would only provide care for between one-fourth to one-third of the dual Medicare military eligibles. Some active duty family members and retirees live near

a military hospital and may be able to enroll in TRICARE prime and get their care for free. Others will be forced into the prime civilian network and have to pay co-payments.

Active duty families stationed in areas without a military hospital and retirees who live in such an area may only be offered the higher cost TRICARE standard. In other words, no one can tell potential recruits what their health care benefit is going to be for their families or for themselves when they retire. DOD may provide certain benefits at one duty station at certain costs, and vastly different benefits at vastly different costs at another duty station.

Upon retirement, a retiree may be forced to move to follow their health care benefit if installations close or hospitals downsize.

When you become 65 and eligible for Medicare, you essentially have no employer-provided insurance. As long as DOD continues to deliver care rather than offer a health care benefit, this disparity in benefits and beneficiary costs will continue, as they will be based on the budget of the deliverer and the needs of the system.

While it is true that TRICARE has worked well for many, those with chronic or continuing illnesses who are particularly dependent upon continuity of care are often ill-served by the system. Referrals between military hospitals and the civilian network more often fall through the cracks than work. TRICARE civilian network providers drop out of the system or limit their number of TRICARE patients because of extremely low reimbursement rates and continuing claims processing hassles.

TRICARE was not designed to serve the entire beneficiary population, and indeed it does not. However, it does have its own bureaucracy. We have bureaucracy at the contractor level. We have it at the DOD level, the lead agent level and at the military hospital level.

NMFA believes that it is time to relieve DOD of trying to provide both a peacetime health care benefit and meet its readiness mission. DOD should concentrate on the readiness mission it alone can provide, and leave peacetime health care to the well-proven system, the Federal Employees Health Benefits Program.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Hickey follows:]

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The National Military Family Association (NMFA) is the only national organization whose sole focus is the military family and whose goal is to influence the development and implementation of policies which will improve the lives of those family members. Our mission is to serve the families of the Seven Uniformed Services through education, information and advocacy.

Founded in 1969 as the Military Wives Association, NMFA is a non-profit 501(c)(3) primarily volunteer organization. NMFA today represents the interests of family members and the active duty, reserve components and retired personnel of the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration.

NMFA Representatives in military communities worldwide provide a direct link between military families and NMFA staff in the nation's capital. Representatives are the "eyes and ears" of NMFA, bringing shared local concerns to national attention.

NMFA receives no federal grants and has no federal contracts.

NMFA has been the recipient of the following awards:
Defense Commissary Agency Award for Outstanding Support as Customer Advocates (1993)
Department of the Army Commander Award for Public Service (1988)
Association of the United States Army Citation for Exceptional Service in Support of National Defense (1988)

Various members of NMFA's staff have also received personal awards for their support of military families.

NMFA's web site is located at http://www.nmfa.org.

SYDNEY TALLY HICKEY
Associate Director, Government Relations Department

As the spouse of a retired Naval officer and an Air Force daughter, Mrs. Hickey has been a military family member for most of her life. She attended Florida State University and was graduated from Johns Hopkins University in 1961 with a B.S. in Nursing. She pursued her chosen specialty of Public Health Nursing in the states of Washington and Florida - and several in between. "Retiring" from remunerated work on the birth of her first daughter, she became a full time wife and mother and part time volunteer.

Her volunteer positions included: Navy Relief interviewer, teaching assistant, Brownie and Girl Scout Leader, Red Cross pediatric nurse, Commissary, Exchange and Hospital Board member, President of four Naval Officers' Wives' Clubs. She continues her commitment to volunteer activities as a member of the Ecumenical Commission of the Episcopal Diocese of Virginia.

In 1983 she joined the Government Relations Staff of the National Military Family Association and served as the Director of the Department from 1987 to 1990. On January 1, 1990, she was competitively selected to become the Association's first paid professional staff member and currently serves as Associate Director, Government Relations. Mrs. Hickey supervises the preparation and delivery of the Association's dozen or so yearly Congressional testimonies, and travels extensively promoting the Association's mission of educating military family members about their rights and benefits.

The Military Chaplains Association of the United States of America selected Mrs. Hickey as the recipient of their 1992 National Citizenship Award. The University of Central Florida presented Mrs. Hickey with their 1993 Defense Transition Services Award for support to military families in transition.

Mister Chairman and members of the Subcommittee, the National Military Family Association is most grateful to you for holding this hearing. Your interest in the health care of military beneficiaries is well documented and extremely appreciated. NMFA also appreciates this opportunity to express its views.

The Military Health Care System

The Military Health Care System has undergone a multitude of changes over the last fifty years. However, two aspects have remained constant throughout all of the changes:

1) All changes have been for the sake of the system and/or cost containment and not for the beneficiaries.

2) The system delivers care to beneficiaries. It does not provide a health care benefit.

Up until the advent of Tricare, all health care delivered by the direct care system in military treatment facilities (MTFs) has been free. In 1956 and again in 1962 free civilian health care was authorized for families of active duty members, when necessary.

From CHAMPUS to Tricare

In 1966 the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was authorized to provide both active duty family members and retirees and their family members an alternative to health care in MTFs. CHAMPUS introduced copayments and deductibles for the first time. Copayments for outpatient care were slightly higher for retirees and their family members. Copayments for inpatient care for retirees and their family members

were set at a significantly higher level. The potential for financial disaster as a result of the high inpatient copayments fostered the development of the CHAMPUS Supplemental policy business, mainly provided by military related organizations. CHAMPUS allowed beneficiaries a choice in civilian providers for outpatient care, if beneficiaries were willing and able to pay the costs of deductibles and copayments. However, beneficiaries who lived near MTFs could be denied non emergency inpatient care in a civilian setting if the care was available in the MTF. Hence, the system retained the ability to keep their inpatient beds full with cases which met the need for graduate medical education or professional skill development. Beneficiaries were therefore often denied continuity of care when non emergency inpatient care was needed.

Military beneficiaries who were Medicare eligible due to age were not made eligible for CHAMPUS but retained their eligibility for space available care in MTFs.

The advent of the all volunteer force turned the active force into a "married with children force." As with the rest of the older U.S. population, the longevity of military retirees increased. The number of those eligible for the military medical system significantly increased. The military health care system responded by staffing for beneficiary care rather than wartime readiness needs. The delivery of newborns became the most frequently performed procedure in MTFs.

Even this staffing model could not meet the increased needs. Access to care began to be managed by the Central Appointment system in imaginative ways. Appointments for care for the following month were made only during a one or two hour time frame on one day of the previous month. If you could not get through on the telephone line or if all appointments were filled by the time you did get through, you had to wait another month to try the process all over again.

The Department of Defense (DoD) reacted to the outcry from beneficiaries by trying a variety of demonstration projects in the late eighties and early nineties, including the CHAMPUS Reform Initiative (CRI) in California and Hawaii and various Catchment Area Management (CAMs) programs. The CRI was basically a contractor controlled program, whereas the CAMs were controlled by the individual MTF Commanders.

At DoD's request, Congress required CHAMPUS payments to be the same as Medicare Diagnostic Related Group (DRGs) payments. While this helped control DoD's costs, it caused some providers to withdraw from treating CHAMPUS patients.

The Persian Gulf War showed the readiness weaknesses in the military medical system. The system had gradually been geared to the peacetime delivery of health care and not war readiness.

The drawdown of active forces and Base Realignment and Closure (BRAC) actions drastically reduced access to MTFs. The population of eligible beneficiaries, however, was not appreciably reduced.

DoD began to plan for the introduction of another form of health care delivery that would combine some of the elements of the CRI, but be primarily based on the CAMs. The focus was on those who lived near an MTF, not on the beneficiary population at large.

In 1993, the new administration began work on National Health Care Reform. DoD modified its plan and designed Tricare as a part of National Health Care Reform. As a part of the National plan, DoD beneficiaries who no longer had access to an MTF would be provided the same choice of plans as other American citizens.

The Promise of Tricare

DoD asserted that under Tricare beneficiaries would have a uniform benefit. Their access to care and the cost of their care would no longer be dependent on where they were stationed or lived. The choices of the three fold option would be available to all beneficiaries.

In reality, because Tricare was designed to go with a system that was not instituted, Tricare does not offer a uniform benefit, nor does it offer choices to a significant portion of its beneficiary population. Tricare actually ignores or "locks out" the most vulnerable of the beneficiary population, the dual Medicare-military beneficiaries over age 64.

Does Tricare Provide a Uniform Benefit?

Tricare is supposed to offer beneficiaries the choice of three options: an HMO like program called Tricare Prime; a PPO like option called Tricare Extra; and a fee for service option called Tricare Standard. Tricare Prime is basically only offered in areas with a large number of active duty families and an MTF. Beneficiaries must enroll in Prime, just as one enrolls in an HMO. Active duty family member Prime enrollees who are able to receive care in an MTF have free care. Active duty family members who must receive care from a civilian provider must pay $12 per visit ($6 per visit for families of E-4 and below). Retirees and their families must pay to enroll in Prime ($230 per individual, $460 per family per year). Enrolled retirees who receive care in an MTF receive it free, those who must receive care from a civilian provider must make $12 per visit copayments.

Active duty family members who are stationed in an area without Prime are left with the higher cost Tricare Standard ($300 family deductible and 20% outpatient copayments). Retirees in areas without MTFs must also use Tricare Standard and have the same deductible, 25% outpatient copayments and daily inpatient charges of approximately $360/day. Because of the excessively high inpatient copayments, prudent retirees also pay for Tricare Supplemental policies.

Tricare Prime enrollees have preference at MTFs. MTFs now will be resourced primarily based on their Tricare Prime enrollment. Space available care is quickly diminishing. Therefore, those who chose not to enroll in an HMO will have reduced access to their military health care benefit in an MTF. Yet, those who chose not to enroll may still be compelled to receive non emergency inpatient care in the MTF and denied continuity of care with their civilian provider. Beneficiaries who are barred from enrollment, the dual Medicare-military eligibles over age 64, may be denied any military health care benefit.

If more MTFs downsize to clinic status, as is anticipated, and if another round or two of BRAC occurs, as DoD has requested, even more military beneficiaries will be denied care in the direct system and be left with Tricare Standard.

Tricare Prime Remote

DoD's much touted Tricare Prime Remote has been demonstrated in Region 11. While the Tricare contractor has been able to find Tricare Primary Care managers for most active duty family members, no attempt has been made to include retirees or their family members in the program. Even active duty families find that they are stuck with the restrictions of an HMO when they enroll in Tricare Prime Remote, but do not have the benefits when they must access care beyond the primary level.

Tricare Prime Remote will not provide a military health care benefit for dual Medicare-military eligible beneficiaries.

Tricare Senior Prime (Medicare Subvention)

DoD is in what has turned out to be a very lengthy process of setting up a three year demonstration program of Tricare Senior Prime. Authorized to begin on January 1, 1998, the first two of six demonstration sites may be operational by the end of 1998. Tricare Senior Prime is Medicare Subvention. Medicare Subvention is when Medicare reimburses DoD on a capitated basis for care DoD provides to dual Medicare-military eligible beneficiaries. In order to receive reimbursement from Medicare, DoD must first spend to the level it spent on the dual eligible population in 1996. DoD will then receive reimbursement for the care it provides above that "level of effort." However, the capitated amount that DoD will receive is approximately 80% of what Medicare usually pays providers.

DoD will have to purchase some care in the civilian sector (some benefits of Medicare are not MTF or military benefits) and it is doubtful if that care can be purchased at 80% of what Medicare would normally pay. DoD will continue to absorb the pharmacy costs for this population, since pharmacy is not a Medicare benefit. It is reasonable to assume that for Tricare Senior Prime to be of economic value to DoD, most of the care for this enrolled population must be provided in an MTF. This leads NMFA to conclude, along with the General Accounting Office (GAO), that only between 20 and 25% of the dual Medicare-military population could be offered care even with full implementation of Tricare Senior Prime.

For beneficiaries, the demonstration programs of Tricare Senior Prime may tend to create more problems than solutions. Beneficiaries interested in an HMO that

is based in an MTF may be disappointed as only a few of them will be offered the enrollment opportunity (approximately 4,000 will be able to enroll at Naval Medical Center, San Diego - 33,625 are eligible). For dual Medicare-military eligible beneficiaries who desire to retain choice and not enroll in an MTF, their access to their military health care benefit in an MTF will be further reduced. If beneficiaries do not have Part B of Medicare, they may not enroll in Tricare Senior.

To summarize, the following beneficiary populations are either denied their military health care benefit, pay more for it, or have fewer choices than others in the beneficiary population:

1) Dual Medicare-military eligibles

2) Disability or end stage renal disease dual Medicare-military eligibles (must purchase Part B to obtain their military health care benefit)

3) Active duty family members not assigned to an area where Prime is offered*

4) Retirees and their family members who do not reside in an area where Prime is offered*

5) Dual Medicare-military eligible retirees who reside overseas (not eligible for Tricare and cannot use Medicare benefit overseas)

6) Retirees under age 65 who reside overseas (not offered enrollment in Prime)

7) Those entitled to a COBRA benefit (not allowed to enroll in Prime and must "buy into" Tricare Standard at the prohibitive cost of $993 per quarter for an individual and $1,996 per quarter for a family)

* Tricare Extra is usually not offered if Tricare Prime is not available

Does Tricare Have Other Problems?

Beneficiaries had already seen a reduction in their choice of providers when CHAMPUS (now Tricare Standard) rates were reduced to Medicare DRG levels. Tricare Prime providers must accept often drastically reduced rates from DRG levels. Mental health providers often receive less than half of what they receive under Tricare Standard. In fact, Prime mental health beneficiaries pay 44% to 55% of the total amount providers receive. This amount of patient copayment is often more than the patient would pay under Tricare Standard.

Claims processing hassles and slow payments have added to providers' problems. Even some who initially accepted the lower rates have dropped out because of claims processing problems. Provider groups in Florida, Colorado, Texas and South Carolina have either dropped from Tricare Prime altogether or have reluctantly returned to the fold after the personal intervention of a Congressman or lengthy negotiations with Tricare contractors. DoD has made hundreds of change orders to the Tricare contracts attempting to fix some Tricare problems.

Beneficiaries find themselves having to be the intermediary between civilian providers, the contractor and the MTF in order to get needed care. Beneficiaries who are promised the system will work for them, often must walk their own paper work through in order to have access standards met or receive care in a timely fashion. Beneficiaries who have complicated or long term illnesses find

themselves continually caught between the MTF and their civilian providers. Referrals must dot every "i" and cross every "t" in just the right manner; referrals take a week or more to get from one office to another; lab and x-ray results take days and weeks to be available from the MTF. Customer service representatives who answer the phone at the Tricare Service Center or the 1-800 number often give conflicting advice to beneficiaries.

Does Tricare Work for Anyone?

Beneficiaries whose need for care is normally at the primary level, and who live near an MTF, have seen their access to care improve under Tricare. Beneficiaries in some Regions, primarily Region 12 (Hawaii) and Region 11 (Washington and Oregon and parts of Idaho) seem satisfied with their access to care and the quality of care in the civilian sector of Prime. Certainly some of the Tricare problems have been related to start up problems. However, Tricare will complete its trek across the United States by this summer. It has been up and running since March of 1995 in Region 11. Some of the problems seem to be systemic and not simply related to start up. In addition, most of the start up problems have been repeated in each of the Regions as they came on line. As each of the contracts is recompeted, history would suggest that the so called "start up" problems may have to be endured all over again.

Why Tricare?

NMFA believes the question of "Why Tricare" needs to be addressed immediately. As more MTFs downsize or close, Tricare will become ANOTHER federal civilian health care program with its own bureaucracy and administrative costs. After over three years of full implementation, Tricare is still unable to provide a uniform benefit with uniform costs to the entire beneficiary population. The most vulnerable of the beneficiary population, the dual Medicare-military eligibles, are dying faster than any program to provide them with their promised

benefit is being developed. Tricare remains a program designed to be PART of a bigger program that did not develop. It is like a spoke without the rest of the wheel.

Is there an alternative that would provide a uniform health care benefit at an affordable cost, preserve medical readiness and not necessitate another bureaucracy to run it?

An Alternative

In 1992 NMFA, recognizing that the free health care in military treatment facilities that had been the backbone of the military health care benefit was rapidly disappearing, proposed a health care benefit plan for military beneficiaries. The active duty member was not included in the plan since NMFA felt then, as we feel now, that the health of the active member is a readiness issue.

We suggest:

Military Health Care Plan - primarily centered in MTFs; care not available in the MTF could be procured using contractors. The plan would be an HMO and require enrollment. It would be offered to the entire beneficiary population to include Medicare eligibles.

Optional enrollment in the Federal Employees Health Benefits Program (FEHBP) - all beneficiaries would have the option of enrolling in a plan within the FEHBP.

Health Care Allowance - Active duty service members would be given a health care allowance for their families. The allowance would cover the cost of a modest HMO within the FEHBP. If service members decided to purchase a

higher cost plan, the differential would be paid by the service members. If the family enrolled in the Military Health Care Plan the service members would forfeit the Health Care Allowance, just as they forfeit their housing allowance when they live in government quarters. DoD would also pay the employer part of the premium.

All other eligible beneficiaries (including those eligible for Medicare) would pay the same premium for their FEHBP plan as do federal civilian retirees.

Would the Military Medical System Disappear?

Some have felt NMFA's plan would cause the direct military care system to disappear. Quite the contrary, we feel our plan would enhance medical readiness. Uniformed providers from corpsmen to doctors would practice in full service military hospitals located where the beneficiary population is adequate to provide full case loads. This select number of hospitals should be able to provide a full range of practice to medical professionals in order to ensure graduate medical education and skill development. Liaisons, some already being formed, with trauma centers in metropolitan areas could increase the level of training needed for medical readiness.

Beneficiaries, the vast majority of whom, are very comfortable in the military setting, will stay with a system that provides quality care, adequate access and a customer friendly environment. Active duty families must find new service providers from orthodontists to Girl Scout troops at each new duty station. Most will not add the burden of finding civilian physicians for each family member if a military hospital is available.

What would disappear are the vast bureaucracies at DoD, at the Lead Agent level, and at the MTF level. Contracts would be negotiated at the MTF level for those services needed to augment the MTF. The Office of Personnel

Management (OPM) would provide the administration for those enrolled in the FEHBP. OPM is able to administer the FEHBP for the entire rest of the federal population without a large bureaucratic machine.

The Decision

NMFA believes the basic decision that must be made is whether DoD should provide a health care benefit to its beneficiary population or just continue to deliver health care. A health care benefit is a cost of doing business, and we believe belongs in the personnel arena and not as part of the DoD Health Care Budget. A health care benefit will stay the same for the entire population or be changed for the entire population. It is a defined benefit that can be understood and compared with other employers' health care benefits.

If health care is going to continue to be delivered, the individual beneficiary will never know what his/her benefit will be from duty station to duty station or year to year. The health care delivered will continue to be subject to yearly budget constraints and the needs of the system.

Isn't it time that military beneficiaries had a system designed to serve them rather than existing to serve the system?

Mr. MICA. Thank you for your testimony and your cooperation on this matter.

I am pleased to welcome to our panel our second witness, Dr. Barbara Glacel, and I highly recommend her full testimony. She won't be able to give that here today. In fact, I am not sure that we can afford to print it—it is so lengthy—in the record, but we should also send the leadership a copy of her full documentary of her unbelievable experience with military health care and TRICARE when we appeal for action on this legislation.

I have never seen anything so well-documented, Dr. Glacel, and I compliment you and I recognize you now for your testimony.

Ms. GLACEL. Thank you, Mr. Chairman, Mr. Cummings. Thank you for giving me the opportunity to testify today. I am sorry that I have this story to tell you, but I am glad that you want to listen.

My message is that the TRICARE medical system is an impediment to good health and the difficulty in access actually deters the achievement of quality medical care. My struggles to achieve access to care have left me with the clear impression that TRICARE administrators believe that breast cancer is no more significant than the common cold.

If an educated woman with 28 years of experience with the military has difficulty understanding and satisfying the bureaucratic requirements, if the wife of a senior ranking active duty officer must fight to obtain access to care, then I shudder to think what the privates, sergeants, lieutenants and their families are suffering under TRICARE.

I know of several breast cancer patients who have had such difficulty in gaining access to TRICARE prime, that their cancers have progressed to much more serious stages before they were provided with treatment.

I was diagnosed with breast cancer in December 1996, while my husband was assigned to Supreme Headquarters Allied Powers Europe in Belgium. In 1997, I had two major operations and 3 months of chemo-therapy in Belgian hospitals.

During this time, I received physical therapy 3 days a week for complications following surgery. During my chemo-therapy, I lost considerable range of motion in my shoulder. Three doctors advised it could be 1 to 2 years of continuous therapy to regain range of motion, because the effects of the chemicals caused additional problems of bursitis, tendonitis, and intra-articular effusion.

In July 1997, just following completion of my chemo-therapy, my husband was transferred to Fort Hood, TX within TRICARE Region 6. As a cancer patient, my highest priority was to re-establish medical care. My 45 pages of written testimony for the record outlined the difficulties of my last 9 months as I have fought the system for access to care.

A few examples must suffice in this brief testimony before you today. TRICARE promises that specialty care will be provided within 28 days of a routine consult. One of my referrals to orthopedic surgery took 47, not 28 days, and therefore, I now walk through my consultation paperwork, which means going to three separate buildings in three different locations, waiting in three lines and in one location merely having an employee put a stamp on a piece of paper.

The TRICARE contractor authorized purchase of a portable TENS unit for my shoulder. Four months after receipt of that unit, I received a letter from the contractor telling me I had not supplied the proper paperwork. The TRICARE representative, who had never seen such a letter before, sent me into the main hospital seeking the paperwork where I followed directions through the basement onto the loading dock through soiled linens and into the warehouse, only to discover that the TRICARE contractor had taken over the function of this now nonexistent office 9 months earlier.

A total of six medical doctors confirmed that my condition required continuous long-term treatment probably for over a year, yet every 4 to 8 weeks, I am required to get more paperwork to be sent to the administrator 100 miles away to review whether I can continue care. During the last months I have had the care decreased from the prescribed 3 days a week to 1 day a week.

I have had care discontinued or the threat of discontinuation. I have had administrators tell me incorrect procedures for how to get authorization for more care. The system has taken more than authorized time in reviewing my requests. And at one point I tried for 3 days before I could get a person to answer the phone. I have even had one TRICARE contractor nursing supervisor yell at me that I was lying, and that she had more important things to do than to return calls to patients.

The TRICARE system looks at me as a series of specific symptoms, not as a complex body in which breast cancer may affect my brain, lungs, liver and bones and in which medication I am taking actually increases the risk for endometrial cancer. At the same time that the TRICARE administration was threatening to discontinue my physical therapy, three surgeons were telling me that I might need surgery to correct shoulder problems. But I couldn't have surgery until physical therapy got me to extended range of motion.

This was the proverbial catch–22. Do we save money in the short-term by not giving me more physical therapy, or do we spend more money later on surgery which requires physical therapy?

As a cancer patient, I have both physical and psychological healing required for recovery. The TRICARE system simply impedes my healing. I do not have the stamina to cope with cancer and to cope with bureaucrats who are either incompetent or untrained, an administrative system that does not consider the prescription from the medical care provider and a system with access that is so difficult that it becomes easier to ignore my own health concerns.

If someone with my experience and the rank of my husband to open doors cannot obtain access to medical care, I do not believe that soldiers and their families who protect this country can obtain access either. This is a readiness and retention issue for our Armed Forces and a moral issue for military members and families.

[The prepared statement of Ms. Glacel follows:]

BARBARA PATE GLACEL

Barbara Pate Glacel is Chief Executive Officer of VIMA International, The Leadership Group of Burke, VA, with branch offices in Central Texas, and Johannesburg, South Africa. Dr. Glacel is an expert in organizational development, leadership, team learning, and executive coaching. She is the author of several books in the fields of political science and leadership development, including *Light Bulbs for Leaders: A guide book for team learning* (John Wiley, 1996). She consults with managers and executives in such organizations as Lockheed Martin, MCI, Atlantic Richfield, NASA, The MITRE Corporation, and Scudder, Stevens and Clark, among others.

Dr. Glacel served on Secretary of Defense William Perry's Quality of Life Task force under the direction of the Honorable John Marsh from 1994 - 95. She served on the U.S. Army Science Board advising Secretary of the Army John Marsh from 1986 - 1990 and was primary author of the Army Science Board's report on the *Army Community and Their Families*, relating family well-being to readiness and retention. In addition, Dr. Glacel has participated in several studies of Army quality of life and spouse employment conducted by the Army Research Institute. She was a contributor to the first large study of Army Families in 1984, entitled *1000 Army Families.*

Dr. Glacel holds a Ph.D. in political science from the University of Oklahoma, and a Master of Arts in human relations from the same university. She holds a Bachelor of Arts in government from the College of William and Mary in Virginia. She has served as an officer on the Alumni Board of Directors of the College of William and Mary and as an officer of her professional trade association, the Instructional Systems Association.

Dr. Glacel is the wife of Brigadier General Robert A. Glacel, U.S. Army. She has been an Army wife for nearly 29 years. The Glacels have three daughters who have traveled the world with their Army family, living in 14 places during the last 28 years, not including two hardship tour separations. Dr. Glacel has been an active contributor to the Army community and has received the Commander's Award for Public Service, the Molly Pitcher Award, the Civilian Service Award, and the Forscom Public Service Award.

In December 1996, Dr. Glacel was diagnosed with breast cancer while living in Mons, Belgium at SHAPE Headquarters. Her surgery and chemotherapy were carried out in Belgium in local hospitals. In July 1997, Brigadier General Glacel was transferred to Fort Hood, Texas. Dr. Glacel continued her health care in the TRICARE Prime system in Region six.

Testimony of Barbara Pate Glacel
Before the Subcommittee on Civil Service of the
Committee on Government Reform and Oversight
U.S. House of Representatives
April 28, 1998

Concerns about Tricare:

- There is considerable misinformation within the system among those who are paid to administer it.

  - We were told not to disenroll from the system in Belgium, but were not allowed to immediately enroll in Fort Hood because we had not dis-enrolled.

- Families have problems accessing medical care when family members are separated.

  - Our two daughters in college in regions which have not let contracts are told not to register for Tricare. However, when they are at home at Fort Hood, they are given the lowest priority for treatment in the military facility.

- The system is so complicated that patients find it hard to negotiate. What is the relationship between Darnall Army Hospital, Managed Care Office, Tricare Service Center, Foundation Health, and Wisconsin Physicians Service? The paperwork required is confusing and bureaucratic.

  - For me to get permission to have treatment which is not available within Darnall hospital, I must go to three separate buildings. In one building, a person merely looks at a computer to check my enrollment and puts a stamp on a piece of paper. At each building, there is a wait.

  - A routine referral from a primary care provider to a specialist must be scheduled within 28 days. If I do not walk my own paperwork through, it has taken as long as 47 days.

  - Review by Texas Medical Providers for care beyond the maximum "authorized" is guaranteed within 24 hours. In my case, it took over four days.

  - Providers and administrators use different terms and different forms. The system kicks back paperwork which slows down referrals, medical care, or payment for care because the wrong block is filled in or different terms are used (e.g. stat/asap/within 3 days; the diagnosis is put in the wrong box)

- Explanation of Benefits (for use in collecting Supplemental Insurance reimbursement) are not automatically sent out. Requests for EOBs are only accepted after payment has been made, necessitating numerous phone calls. Nonpayment of a claim does not trigger any action for review, therefore not picking up clerical or data entry errors. This results in nonpayment to providers and denial of an EOB allowing me to collect from my supplemental insurance.

• The standard of care allowed in the Tricare Prime system is set by an average, not by medical need nor by what the doctor orders. It looks at short term financial advantage over long term health needs.

- Despite doctor's orders of care 3 x a week for up to a year, the administrators were able to decrease care to 1 x per week with frequent threats of discontinuation. Renewal of authorization was every four to eight weeks and was a bureaucratic nightmare.

- The orthopedic surgeon indicated I might need surgery on my frozen shoulder. The general surgeon told me I couldn't have shoulder surgery nor reconstructive surgery until I had full range of motion. Physical therapy was the means to full range of motion. Yet, the Tricare Prime administration continued to decrease my authorization for physical therapy. This was a catch 22.

• The myriad of different organizations charged with administering the Tricare Prime system is so confusing that neither the employees within those organizations nor the patients know how to manipulate the system to gain access and quality health care.

- Although Foundation took over all issue of hospital equipment in spring 1997, Foundation wrote to me asking for a statement of nonavailability from the medical issue facility for the TENS unit of which they had approved purchase. The staff at the Tricare Service Center did not have any idea how to handle that problem.

• The system is not open to feedback.

- I asked at the Tricare Service Center on four different occasions how to get feedback into the system that the bureaucracy was impeding my health. Four people knew no more than that there was a suggestion box in the lobby.

- When I discovered that there was Lead Agent in San Antonio, I sent an e-mail through the Region VI web site. My pro forma response from a Major told me to call the 800 number which I had already spent

hours trying to call without success. My return e-mail asked for someone in authority to contact me. From 14 January until today, no one has contacted me.

- Even after I have tried to get feedback into the system, a billing problem with my daughter's treatment from a year ago in Belgium was referred to Region VI because we now live there. Region VI claimed we were not enrolled.

• The Tricare Prime system views me as a series of discreet symptoms, not as a system of interrelated problems which affect one another.

- My physical therapy needs are not viewed as having been complicated by surgery, chemotherapy, and future surgical needs.

• The Tricare Prime system is not set up in a way to be customer friendly. Some of the Beneficiary Services Representatives and some of the Health Care Finders are either untrained or incompetent, and in one case downright rude. Accessing information by phone is close to impossible.

- BSRs and HCFs do their discreet job and do not help with overall medical questions and paperwork problems.

- The 800 number is usually busy; no answering machine; a message says to call back later; in one case, I stayed on the phone letting it ring until a recorded message from the phone company asked me to hang up because my party was obviously not answering.

- One BSR sent me to a non-existent office in the hospital. I was directed into the basement, onto the loading dock, through soiled linens, and to a receiving office where the very kind employees thought I was crazy.

- The Health Care Finder supervisor yelled at me that I was not telling the truth when I was following the exact instructions she had given me for obtaining authorization for more care. She told me I was lying that she had ever agreed to call me back about a previous problem, saying she had more important things to do.

• The Tricare requirements for re-authorization of care are not compatible with medical requirements for follow up.

- Renewal of authorization may be in four or eight weeks while the doctor only wants a follow-up in six weeks or three months. No allowance is made for this discrepancy. The patient is left to work the appointment system to try to get a doctor's appointment without a referral in order to maintain prescribed care on a different schedule. To

get to see a doctor at the right time to get a renewal certifying medical necessity, the appointment must be made so far in advance that there is no clear need for which to book an appointment.

- Services which are offered are not fully funded, raising patient expectations which cannot be met.

- On enrollment, I filled out a health survey and returned it to Foundation. The response outlined my risk factors and chronic conditions and stated a Primary Care Manager would contact me. I am told that this preventive care is not funded and that the reports simply go into a box somewhere and are not reviewed.

- Access to care is so difficult to attain that quality of care suffers. Once the care provider is reached, the care is usually great. The providers don't like the system any better than the patients do.

The bottom line is that the system itself impedes healing, the very purpose for which the system was created.

What follows is a chronological report of one cancer patient's experience with treatment in the Tricare Prime system:

December 20, 1996
After mammogram, ultrasound, and two biopsies, cancer is confirmed
Consultation by phone at Walter Reed Army Medical Center and at Jules Bordet Cancer Clinic, Brussels

January 6, 1997
Lumpectomy and axillary dissection performed in Belgium
Physical therapy begun while in hospital and exercises continued at home
Pathology reports confirmed positive lymph nodes and additional cancer.

January 21, 1997
Mastectomy performed in Belgium
physical therapy continued in hospital and exercises continued at home

January 28, 1997
Physical therapy 3 times a week begun at SHAPE clinic to prevent lymphedema and to increase range of motion

Abduction	70
Flexion	95

Daily exercises done at home continuously throughout all of 1997 to present 1998

February 3, 1997

Abduction	85
Flexion	105

February 13 - May
AC Chemotherapy regimen begun in Belgium
Increased pain in shoulder limited improvement in range of motion (Note: significant shoulder pain increased from February through June to the point that patient could not sleep, lift, or be touched in certain positions.)

March 8, 1997
Began taking anti-inflammatory drugs for shoulder (Naprosyn). The drug could only be taken during certain times of the chemo cycle and could not be used over a long period of time.

March 24, 1997
Visited Dr. Dave Jaques, head of surgery, and Dr. Lou Diehl, head of oncology, at Walter Reed Army Medical Center, for consultation to support treatment in Belgium.

May 1997
Started using TENS unit issued by physical therapy clinic
Chemotherapy regimen complete
Started taking tamoxifen daily as a hormonal cancer treatment.

June 1, 1997
X-ray and Ultra sound revealed significant tendinitis and adhesive capsilitis
Range of motion decreased to:

Abduction	70
Flexion	90
Internal rotation	30
External rotation	5

2 June 1997
Physical Therapy changed to begin interferential treatment for 15 minutes, stretching, mobilization and ice massage

11 June 1997
Final appointment with breast surgeon at Jules Bordet Clinic, Brussels. She explained that the frozen shoulder was not usual, but also not abnormal. Typical treatment was physical therapy for one to two years. Full range of motion should be regained within two years. The length of time is based on the fact that chemotherapy treatments worsened the condition and significant work must be done to regain motion lost during chemotherapy treatment.
Appointment with Orthopedic surgeon; received cortisone injection which relieved pain and allowed more aggressive physical therapy; suggested possibilities of turgescent bursitis and intraarticular effusion. He indicated that regular physical therapy treatment for a minimum of one year was indicated.

4 July 1997

Abduction	85
Flexion	135
Internal rotation	65
External rotation	40

11 July 1997
Departed from Belgium on Permanent Change of Station to Fort Hood, Texas. We were told not to disenroll from Tricare so that our service would not be suspended during change of duty station. No physical therapy from 10 July through 12 August 1997.

17 July 1997
Surgical appointment with Dr. Shriver at WRAMC for follow up to telephone consultation during treatment in Belgium.

18 July 1997
Arrival in Fort Hood
Within the week, General Bob Glacel (husband) began the Tricare Prime registration process, only to find out that family members had to disenroll from Tricare at previous duty station before they could be enrolled here (the exact opposite of instructions in Belgium).

23 - 25 July 1997
Called secretary (Carol Casson) of hospital commander (COL Ken Farmer) to schedule an appointment in accordance with procedure for GO families to obtain appointments as explained by my predecessor; Carol was noncommittal and called back within the week to explain that she no longer booked appointments for families of General Officers and that I should contact Major Lisa Gross at Managed Care

28 - 31 July 1997
Spoke with Major Gross on several occasions. She was about to go on leave and she referred me to Sue Schmidt in Internal Medicine. Through the assistant, Tamara, we arranged a meeting to facilitate disenrollment and re-enrollment in Tricare Prime. We discovered that one of the children (Sarah) had been dropped from DEERS and that was corrected. Sue booked me to see Dr. Zawacki in Internal Medicine.

1 August 1997
Appt with Dr. Zawacki
General exam and referrals to physical therapy, oncology, allergy, dermatology. In order to get physical therapy immediately, I was encouraged to walk the paperwork through.

6 August 1997
Walking through the paperwork required going to the Managed Care office (separate building from the hospital) so someone could look me up in a computer and put a stamp on the consult. Then, I had to go to the Tricare Service Center (separate building from both hospital and Managed Care) and log in to wait for a health care finder. The referral was for physical therapy three times a week, but the system only allowed two times a week despite physician's request. Given 8 sessions over 4 week period (12 August - 6 September). Met with Kecia Cobler, Health Care Finder. (Authorization # 9721800530). She explained that at the end of four weeks, the physical therapist would request extension.

12 August 1997
Oncology appointment with Dr. Atkins, resident from Brooke Army Medical Center
Referral to general surgery, plastic surgery and prescription for TENS unit
Started physical therapy again after a month's non-treatment

Abduction	110
Flexion	115
Internal rotation	35
External rotation	45
Extension	30
Adduction	20

14 August 1997
Visited the Tricare Service Center to determine how to acquire a TENS unit. Met with Barbara Melikan, Health Care Finder, who was very helpful. She determined that the purchase of a TENS unit was more cost effective than paying for rental for several months. She arranged with Apria Health Care to send me a unit and I paid the cost share. Barbara reviewed my case and extended my treatment to 16 sessions over 8 weeks (through October 3) on the same authorization number.

26 August 1997
Physical exam with Dr. Zawacki
Referral for mammogram and pap smear in the fall

28 August 1997
Resumed use of TENS unit purchased from Apria Health Care through Tricare.

Late August
Received letter from Managed Care saying Oncology was not available at Darnall. I had already seen oncologist at Darnall on August 12. I learned later that Managed Care sent the nonavailability letter to me thinking I would prefer care at Scott and White so I could see the same oncologist every visit. However, no one told me that. I simply received the letter of nonavailability which arrived after I had already been seen in Darnall.

Physical Therapy appointments:

August	12
	14
	25
	28

9 September 1997
Plastic surgery appointment with Dr. Day to consult on reconstruction and scar revision.

11 September 1997

Abduction	145
Flexion	160
Internal rotation	80
External rotation	65
Extension	35
Adduction	45

18 September 1997

Dr. Zawacki gave me a consult to Orthopedic Surgery for re-evaluation based on recommendation by physical therapist. This piece of paper walked itself through the system rather than my hand carrying it as I usually do. It was stamped Sept 26 received by Foundation Health. Another stamp showed receipt on Oct 1. It took 8 days to get across the parking lot and another 5 days to get to the building next door. Care is promised within 28 days. When I did not receive an appointment notification, I walked into Orthopedic Surgery and booked my own appointment. I was called subsequently by Managed Care and offered a November 4 appointment. I told them I had already booked my own. Had I waited for the system to work, it would have been 47 days, far over the standard for routine service. It would also have left me without needed physical therapy for four weeks while I waited for the orthopedic evaluation.

Late September

Barbara Melikan called to tell me she was taking a job in Managed Care and leaving the Tricare Service Center. She recommended that if I needed assistance, I call Tonya or Lorraine. Because I had only used 11 of the 16 sessions, she gave me authorization for another 8 sessions (October 6 - 31).

Physical Therapy appointments:

September	2	18
	8	30
	11	
	15	

7 October 1997

Abduction	145
Flexion	145
Internal rotation	25
External rotation	70
Extension	40
Adduction	25

Physical therapist notes that range of motion in supine position is better than these measurements which were taken sitting up. He recommends continued physical therapy.

October
At some point, TENS unit was only functioning on one frequency. I called Apria and they sent out a new one. They said to package up the old one and they would send a call slip through UPS. That never happened.

9 October 1997
Orthopedic appointment with Dr. Grant

Abduction	170
Flexion	160
Internal rotation	50
External rotation	70

After viewing the x-rays taken in Belgium, Dr. Grant expressed concern that I might need surgery on my shoulder. However, it was important to regain motion before having surgery so that the frozen shoulder would not get worse. Surgery would be based on pain.
Dr. Grant gave another consult to continue physical therapy and asked for a patient follow up in 8 weeks
I returned to Managed Care and Tricare Service Center with consult from Dr. Grant to extend physical therapy. Managed Care office told me that it was the wrong form and I would have to go back to Orthopedic Surgery. I refused and they called Tricare Service Center who agreed to see me. Met with Dee Smith, Health Care Finder. (Authorization # 9728200654 for 8 visits from 14 October to 14 November). Dee explained that after those sessions, we would need to fax San Antonio for authorization for more visits because I had completed the 20 allowed. She said the procedure was very fast and to call one week prior to the end of the authorization. At this time, I explained to Managed Care and Tricare Service Center that the system was wearing me down. As a cancer patient, trying to recover physically and psychologically, it was increasingly difficult to fight a system which was so bureaucratic and unwieldy. I asked why the doctors, Managed Care and Tricare Service Center didn't cooperate more with each other and I asked how I could provide feedback that there needed to be improvement. Dee responded that she didn't know.

10 October 1997
Given 3 pound hand weight for home exercises
Phone conversation with Dr. Jaffin, surgeon. He said that before any orthopedic or reconstructive surgery could be considered, full range of motion would have to be regained or would set back progress.

October 16, 1997
Met with COL Ken Farmer, Darnall Hospital Commander, to describe to him the bureaucratic hassle for a cancer patient to get care at Darnall and within the Tricare system. During this conversation, I found my own lack of stamina was evident in that it became increasingly difficult to describe my fight for care without losing my composure. Dr. Farmer expressed his embarrassment that a cancer patient would have to fight the system so hard.

17 October 1997

Abduction	150
Flexion	170
Internal rotation	65
External rotation	85
Extension	45
Adduction	30

18 October 1997
Mammogram performed. This was a Saturday appointment and the technician asked why I was scheduled on a Saturday when there was no radiologist to read the film. She said that breast cancer patients are never scheduled when there is no radiologist on duty. Mammograms after breast cancer are emotional events, and clearly the person who scheduled the appointment did not recognize this.

20 October 1997
Returned to Radiology clinic to get results of mammogram.

25 October 1997
A letter from Foundation Health was sent to me stating that I was at risk for Angina and Heart Attack in close family member, and that I have chronic conditions of high blood pressure, cancer, bone, joint, back or muscle problem, and family member with heart disease. The letter states that my primary care provider will schedule a meeting to discuss these findings. I have never had such a meeting scheduled nor heard from anyone about this letter. I am told that resources are not provided to respond to these survey results and that the reports go into a box somewhere. (See Attachment A)

Physical Therapy appointments:

October	2	17
	7	20
	10	22
	14	30

3 November 1997
Pap Smear with Dr. Zawacki
Surgical appointment with Dr. Jaffin. This was my first surgical appointment since arrival in July. Normally breast cancer patients are followed up by the surgeon every three months during the first two years after treatment.
Follow up in 3 months

11 November 1997

Abduction	160
Flexion	175
Internal rotation	75

External rotation	70
Extension	70
Adduction	45

14 November 1997
Plastic surgery for scar revision performed by Dr. Day
Peno Carter Physical therapy clinic requests extension for physical therapy
I requested continued care from Dee Smith at Tricare Service Center. I explained to her that I had a valid doctor's opinion that I needed continued care, perhaps for a year, and that the struggle to get permission from Foundation was impeding my healing. It simply wears me down. I asked how to get feedback to the system that their short range practices and decisions for saving money might cause more expenditure in the long run if I ended up having the surgery suggested by the orthopedic surgeon. Dee said they get feedback from the providers but not the patients.

18 November 1997
Oncology appointment with female oncologist from BAMC. No report is in the medical records to indicate what she did or who she was.
Plastic surgery follow up with Dr. Day.

20 November 1997
Phone call with Dee Smith telling about new authorization from the Medical Director which limited visits to one time a week. (Authorization # 9732101193 from November 21 to December 12). I was very upset about the lack of assistance I was receiving in order to get care ordered by the doctor. I explained that two times a week was the prescription, not one. I asked why the system was so difficult and commented that it impeded my psychological as well as physical healing. Dee said there was nothing she could do.
I asked when they started counting number of visits per year–fiscal year or calendar year. She didn't know and would have to check. She called back to say calendar year and that after January, we could start again as if it were new service.
She called back 30 minutes later to say she was wrong and I would have to start the process over with Primary Care provider and consult through managed care as if I were a brand new patient after the first of the year.

Physical Therapy appointments:

November	4	21
	6	25
	11	
	13 (end session)	

Early December
Received a letter from Foundation Health in Wisconsin stating that I had never provided proper paperwork for the TENS unit and that if I did not provide a

nonavailability statement, I would be forced to return the unit or be charged the entire cost. (See Attachment B)

8 December 1997
I took the letter to the Tricare Service Center. After an hour wait, I met with Towanda Everhart (Beneficiary Service Representative). She had never seen such a letter and didn't know what to do with it. I suggested she ask a supervisor or call Wisconsin. She did both. The person in Wisconsin said that I needed the paperwork. I asked Towanda where to get it and she didn't know. I suggested she find out. She asked a male nurse who used to work in Darnall Hospital. He said I went to an office in the basement of the hospital to the Medical Equipment Supply and got the letter of nonavailability there. I told Towanda how frustrated I am with the Tricare system and asked how to speak to someone in charge who could make a difference. She said there was a suggestion box in the Service Center, but she didn't know how to get any other feedback to someone in charge.

8 December 1997
Orthopedic follow up with Dr. Grant. He was pleased with the decrease in pain and provided instructions and rubber tubing for home exercises. He wants me to continue physical therapy and return to see him for a follow up in 6 - 8 weeks. This timing will not work to start the process over in January, so I book a five week appointment.

9 December 1997
Plastic surgery follow up and release from Dr. Day.
Following my appointment, I went to the basement to find Medical Equipment Supply. There were no signs to such an office. A hospital employee stopped me in the hall asking if I needed assistance. He directed me out onto the loading dock, through soiled linens, into the warehouse, and to an office behind a large glass window. The two people in the office had no idea what I was talking about when I explained why I was there. They picked up the phone and called Mr. Miller and gave the receiver to me. He said that the hospital had not issued medical equipment since March 1997 because Foundation had taken over all medical equipment even for active duty. Therefore, there was no such thing as a statement of nonavailability and that Foundation was the only issuing facility. He directed me back to the Tricare Service Center. When I explained that they are the ones who sent me on this wild goose chase, he said to go to Major Gross at Managed Care.
I went to the Managed Care office and Major Gross was called out of a meeting. I reminded her that I had spoken with her by phone in July, but this was our first meeting. I told her about the wander around the basement and she immediately called for someone from Tricare to come to Managed Care. Linda Womack, Health Care Services Supervisor, came and sat with us. Linda took a copy of the letter, said she would find out about it and would get back to me. I mentioned that I was very unhappy with Tricare and that I had been reduced to one physical therapy session a week which ended the following week. I had been told I could not get any more care between December 12 until after the New Year. Major Gross said she would call Dr.

Zawacki and get another consult for me. Linda explained that after the beginning of the new year, the process would begin anew and I would be authorized 20 more sessions as routine care without appeal to San Antonio. She said it would be as if I had a new consult and all I needed was a referral from a doctor.

12 December 1997
Major Lisa Gross called to tell me there were four more visits authorized from December 15 - January 9. (Authorization # 9734500086 good for one month). Physical therapy notes indicate this call came to them from Lucy at Tricare, but Lucy did not call me.

18 December 1997

Abduction	170
Flexion	175
Internal rotation	75
External rotation	85
Extension	75
Adduction	75

Physical therapist notes that the shoulder is noticeably stiffer than usual, probably due to the ten day period between treatments.

19 December 1997
Bob met with COL Ken Farmer (Darnall Hospital Commander), Mike Case (Tricare Service Center Manager) and Linda Womack. He explained that the system was broken in getting me needed care. He talked about poor care provided to the families of his soldiers, specifically Toni McLeod. He reminded Linda Womack that she was to call me to let me know the disposition of the TENS unit confusion.

Physical Therapy appointments:

December	8	31
	18	
	22	
	29	

14 January 1998
I was able to have the Orthopedic follow up with Dr. Grant.

Abduction	180
Flexion	170
Internal rotation	60
External rotation	80

He said the frozen shoulder is improving but still needs physical therapy, recommended 3x a week. Follow up in 3 months if needed. Because of decrease of pain, he thinks there is not a need for surgery at this time.
In accordance with instructions from Linda Womack and Major Lisa Gross, I took the new consult to Managed Care for confirmation of Prime status and then to the Tricare Service Center. I was summoned to see Linda Womack and met Pam Scott

(Health Care Services Manager) who would be my case manager. I first asked Linda about the TENS unit. She said that had long since been taken care of, and I reminded her that she was supposed to call and tell me that. She denied that she was ever supposed to call me. Then I asked about starting care again based on the new consult from Dr. Grant. Linda Womack explained that we needed a report from the physical therapist to send to San Antonio for approval from the Medical Director since I had used my allotment of allowed physical therapy. I explained that both Linda and Lisa Gross had told me that the new year started counting again and that I needed a doctor's referral in order for standard authorization to take place. Linda became agitated and raised her voice. She claimed that someone named Lucy had called me to give me the authorizations before Christmas and explained to me that we needed approval again. I told her I had never spoken to nor did I know anyone named Lucy. Lisa Gross had called me to give me news of the authorization and said we would start over in the new year with a new consult and a new twenty sessions allowed. Linda became loud and rude, telling me that I was not telling the truth. Pam tried to calm us both as I said yet again that the system was patient unfriendly and was actively impeding my healing. I asked again how to get feedback into the system and was told there was a lead agent in San Antonio and I could provide feedback there. This is the first time I have received an answer to my question of how to get feedback into the system. I came home and called the physical therapist who sent another request for treatment. I also wrote to Congressman Ike Skelton, Deputy Assistant Secretary of Defense Carolyn Becraft, and Vicki Crouch, wife of the U.S. Army Vice Chief of Staff. I sent an e-mail message to the Lead Agent's office for Region 6 in San Antonio. Bob spoke to the Medical Director, Dr. Edward Haines (1-210-321-2004), and it was an unpleasant conversation.

14 January 1998
Message sent via Tricare Region 6 Home Page:

Your service is actively impeding my physical and psychological healing from breast cancer and adjuvant treatments. The details are far too long to write. I would like to be contacted by someone who has authority, not a functionary who merely states that "the system makes me do it." Tricare is extremely patient unfriendly.

Automatic response:
Thank you for sending us your comments. If you have asked us to contact you, we will respond by email if given.

We thank you for taking the time to help us serve you better...

Sincerely,

Col Richard Bannick, Executive Director
TRICARE Southwest

15 January 1998
Spoke to Major Lisa Gross, head of Managed Care. Explained problem to her and she remembers it as I do—that Linda Womack was to call me about TENS unit; that we started new in 1998 with new consult. She will talk to Mike Case.

16 January 1998
Pam Scott called and authorized 9 more visits. I could have them 3x a week for 3 weeks or less often from January 14 until February 27. I was to learn a home exercise routine and would not be allowed further physical therapy after this authorization. I explained that I am already doing exercises at home and that the professionals make a big difference in recovery. I asked how they would handle electrotherapy at home? She said we'd face that when we came to it.
(Authorization # 9801401093)

20 January 1998
Message received from Tricare Region Six:

Dr. Glacel,

In reference to your request to contact someone about the TRICARE health care system, I suggest starting with the Beneficiary Service Representative (BSR) 1-800-406-2832, Option #3. Not having any detailed information about your situation limits me to this single suggestion. But in the vast majority of cases, the BSR will be able to help you with information on providers, claims, and benefit clarification. If the BSR is unable to provide you with specific information you need, please let me know. We work with the contractor (Foundation Health Federal Services, FHFS) to ensure all contractual requirements are met. We understand how frustrating sometimes a new health care system can be and our goal is to ensure each Military Health Service beneficiary has access to quality care. Please let us know if you continue to questions.

Major Richardson
DoD Region 6
San Antonio, TX

My response on same day:

Major Richardson:

Thank you for your reply. Rather than deal with a broken system at the local level, I have scheduled an appointment with Dr. Mazzuchi, Deputy Assistant Secretary of Defense (Clinical Services) HA in Washington, D.C. I have spent far too much time and energy trying to make the Tricare Center at Fort Hood and the Medical Director in San Antonio understand the continuing needs of cancer patients. I am tired of

poor customer service and a lack of patient care. If there is someone in Region 6 who cares about improving the system, that person can contact me.

Barbara Pate Glacel, Ph.D.
6795 Patton Drive
Fort Hood, TX 76544
(254) 539-6383

Note: As of April 28, no one in Region six has contacted me about this message.

Physical Therapy appointments:

January	9	28
	19	
	22	
	26	

5 February 1998
Oncology follow up with Dr. Diehl at WRAMC. Having seen a different oncologist at each visit, and having no continuity of care, I booked an appointment with Dr. Diehl for my annual check up. He spent a considerable amount of time answering my questions, and commented that I seemed "starved" for information which seems unavailable at Fort Hood in this piecemeal system of care. He explained that because I am taking tamoxifen for five years, I am at increased risk for endometrial cancer and must have uterine ultrasounds annually on the anniversary of starting tamoxifen, and that PAP smears should be done by doctors familiar with tamoxifen.

12 February 1998
Spoke with Pam Scott in Austin (1-800-977-8442 ext 6149) about the need to extend care. She said that the policy is not definite at 20 visits, but we need to show a medical necessity with Doctor's orders plus a report from the Physical Therapist to show that the treatment being received is showing progress. Foundation assumes that something is wrong with the therapy if a patient needs more than the average of twenty a year. I will get the appropriate reports, and she will recommend that these reports be sent out to a like specialist for review. I developed a spread sheet of my range of motions measurements to demonstrate that the therapy is working and that the chemotherapy was a major factor in deterioration of my condition. (See Attachment C)

13 February 1998
Received a voice mail message from Laura Gill at the Tricare Service Center asking how she could help me about processing the Champus Supplement claim and saying she had the claim for the prosthesis. She left 1-800-406-2832 option 3 as a return phone number for her or Elizabeth.

17 February 1998
I returned the call to Laura Gill on the next business day. I tried to reach her at the 800 number, option three which she indicated, and then the option for the Fort Hood service center. No one answered the call and finally a recorded message came on asking me to hang up because there was no one at the number I was calling. I called Pam Scott and left her a voice mail asking that someone contact me. After no response, I tried to call again and got the Fort Hood Tricare Service Center. I was told that Laura Gill was in Austin. When I called back, I got Elizabeth in Austin. She did not know anything about the message from Friday and I was on hold until Laura got off the phone. She was very nice and explained that she had ordered the EOBs for me. For future EOBs, I can call her. She said that Champus had received

the claim for purchase of my prosthesis and was returning it to me because the doctor did not write a diagnosis on the prescription. I asked how many diagnoses there were for breast prostheses? She then asked about the claim to Apria for the TENS unit. The record indicates that a statement was received that the Medical Treatment Facility did not have TENS units available, but Apria had not been paid because the prescription did not have length of time for treatment. At the time the TENS unit was prescribed, there was no length of treatment known. Since the unit was purchased, it seems to me not to be a necessary statement. I also explained to Laura that I still had the non-functioning TENS unit which Apria had never picked up from me. She will let them know as she checks the status of that claim.
Laura called back to say she had checked with Apria. They sent her a copy of the prescription, but she needs to add a length of time. I told her I used the TENS regularly for about three months and that I use it now only as needed for pain. With that information, she can process the claim. She forgot to tell Apria to pick up the non-functioning TENS unit.
I found the prescription for the prosthesis which clearly states mastectomy. I asked her what other diagnosis they need? She thinks that because mastectomy was written in the "reason for request" block and not the "provisional diagnosis" block that they need to have the provisional diagnosis filled in. She said, "Let's just appease them and when you get the letter, write it in the right block." (See Attachments D and E)

I hand-delivered the following note to Orthopedics:

February 17, 1998

Dr. Grant,

Once again, I need your help to get authorization to continue physical therapy. After I saw you on January 14, the Foundation Health Medical Director in San Antonio reluctantly gave me 9 more visits for physical therapy which will end February 24. Instructions were that I was to learn a home exercise routine and no more care would be authorized.

The fact is that I have been doing home exercises since January 1997 when I had surgery for breast cancer. Nonetheless, the care of a trained professional who understands anatomy and manipulation has proven to be essential to my improvement. I was recently out of town for two weeks during which time I did exercises with a 3 pound weight and with the surgical tubing. My husband helped me with stretching exercises. When I returned to therapy, I was very tight and had much more pain in order to regain flexibility and range of motion. My husband and I simply don't know the nuances of position to do the exercises as well as the therapist. Often, I end up in much more pain from trying to force something in the wrong way when my husband does the stretching for me.

My Tricare case manager says we need justification from both the doctor and the therapist. Attached is a letter from the therapist. I would greatly appreciate it if you could write a detailed consult explaining that:

- physical therapy is helping. The fact that I need more doesn't indicate that the regimen is ineffective, which Foundation claims.
- because my physical condition was complicated and worsened by chemotherapy, the healing and regaining of range of motion is taking an extended time.
- that home exercises are in addition to, not a substitute for, professional therapy.
- that discontinuation of improvement now can possibly cause more problems in the future.

The letter must be VERY specific as to what care is prescribed, how often, and how soon. Since my authorization runs out on February 24, you have to say that care is needed within 3 - 5 days of the consult. Otherwise, they will get back to me in 28 days.

While I was in Washington last month, I met with the Deputy Assistant Secretary of Defense for Health Affairs. He has asked me to document my struggle for access to care, which I am doing. It is quite a laborious task.

Please call me at 539-6383 and I will come by the clinic to pick up the paperwork. If it goes through distribution, it will never make it by the deadline. Thank you so much for your help.

Barbara Glacel

17 February 1998
I requested an appointment with Dr. Zawacki, the internist, for confirmation of medical necessity for physical therapy. The earliest I can be seen is Wednesday, February 25, after the date of end of treatment.

19 February 1998
Called orthopedics because of no response to my request to Dr. Grant. I was informed that he was very busy and probably could not see me if I walked in. I went to Managed Care for a meeting that was canceled. Major Gross walked me through Surgery and Orthopedic Surgery. She will get the consult form Dr. Grant later today and will book a general surgery appointment for me in March. I provided her with two statements from physical therapists confirming my need for continued care. (See Attachments F and G)

Received a form letter from Laura Gill that she had requested my EOB statements to file for Champus Supplement. EOBs for four dates were missing.

23 February 1998
Pam Scott called with information about dates and authorization numbers and names of Health Care Finders and Beneficiary Service Representatives I had seen. She received the paperwork from Dr. Grant, but she needs more specific information from Dr. Grant about number of times per week I need to be seen and

she has called Darnall. She will submit paperwork for continued treatment to Dr. Haines and Texas Medical Providers. She will call me back. I asked her to explain the organizational structure of Foundation. Linda Womack works for Pam. Pam and Mike Case are peers. Mike is administrative manager and supervises the BSRs. Pam is clinical services manager and supervises the health care finders.

Called Laura Gill in Austin to check on missing EOBs. I was answered by Wisconsin and told they don't transfer calls. Tracy in Wisconsin will send a message to Laura in Austin asking her to call me.

24 February 1998

For two days, I have been unable to reach Austin and have not received a return call from Laura Gill. Finally, I decided to speak to Nicki Wiltzius (Employee # 292, Customer Service Rep) in Wisconsin about the missing EOBs. She pulled up my file and informed me that on October 30 and November 11, Peno Carter and Linda Pace were listed as unauthorized providers. Despite the fact that they have been continuously providing care and were authorized before, between and after those dates, the system says that on those dates they were restricted from providing me care. They will have to get that restriction removed.

For the December 18 date, Nicki says that I was not authorized for treatment. She shows that Authorization # 9734500086 good for December 15 - January 9 did not actually start until December 22. I told her that both Carter Physical Therapy and I were informed it began on December 15. She says that a health care finder will have to change that date in the records before the bill will be paid and I am credited with my cost share.

Foundation has also received invoices for January 22, 26, 28 and is processing those claims. I asked that EOBs be sent to me, and I was told that there is no way to request the EOBs until after the claim is paid and I will have to call back to make that request.

I called Pam Scott in Austin (800-977-8442 ext 6149) and told her of these problems. She will contact Laura and get answers about correcting the billing problems. She explained that WPS is the fiscal intermediary and handles the money. There are major glitches between Foundation and WPS. She thinks that when a claim is denied that the system should generate a message which calls for a special look at the claim. Instead, it is left to me, the patient, to make numerous phone calls and straighten out the system for them.

She has forwarded my paperwork for continued physical therapy to Dr. Haines who forwarded it on to Texas Medical Foundation. A response is expected within 24 hours. In order for me not to miss another session in February, they are authorizing one more visit this week on the previous authorization code.

I told her that I received the claim for the prosthesis back to me asking for diagnosis. The doctor's order clearly states mastectomy. Both Pam Scott and I are unsure what else Foundation wants in order to process this claim. I will mail it back on February 25.

Lisa Gross called to inform me that I have an appointment in General Surgery on March 2 at 9:40 a.m.

25 February 1998
Appointment with Dr. Zawacki. Dr. Diehl had told me that a routine bone scan, liver scan and x-rays were not performed. Rather, symptoms dictated tests and I must be attuned to pain, cough, headaches, etc. I brought Dr. Zawacki up to date on my appointment with Dr. Diehl. She did a physical breast exam and we talked about symptoms. She ordered chest x-rays (regular and oblique), elbow x-rays for pain, blood test for liver functions, and uterine ultrasound at the one year anniversary of my beginning tamoxifen.
I finally reached Laura Gill very late in the afternoon. She said Pam had corrected the authorization date for the December 18 physical therapy visit. For the October 30 and November 11, the claim is denied because it states that Linda Pace, a physical therapy assistant provided the care. I explained that because I have several different procedures that different people might set up the electro-therapy or the ice massage, but they work under the supervision of a physical therapist. She said they are not allowed to pay the claim unless the physical therapist's name is on the record. I checked my copy of the P.T. records and it clearly states the physical therapist, Peno Carter. (See Attachments H - M)

26 February 1998
I explained the problem to Peno Carter and he will re-bill making sure his name is on the claim.

27 February 1998
I tried to call Pam Scott in Austin and left her a voice mail. Later, she attended the Process Action Team Meeting in Managed Care, so I told her about the message and explained that I had made an appointment for Monday, March 2, and would have to cancel it if she did not have a new authorization for me. She said that although Texas Medical Foundation is required to give a reply in 24 hours, she had not heard back from them in three days. Therefore, she verbally authorized me another visit on the old authorization number.

Physical Therapy appointments:

February	10	24
	12	26
	17	
	19	

2 March 1998
I had a physical therapy appointment at 8 a.m. even though neither the P.T. clinic nor I had received authorization. I had a surgical appointment at 9:40 at Darnall Hospital and waited 90 minutes before being seen. I am now in the system with Dr. Carole Ortenzo and she will see me every three months. She gave me consults for mammography.
I called Pam Scott and left a voice mail asking about authorization for continued care. She returned the call and gave me a new authorization (# 9805500079 for 18

visits between March 2 - May 30.) I called Peno Carter Clinic and gave them the information. The assistant there had talked to a Lisa at Tricare who said I needed to go back to see a doctor. We decided to ignore this advice since her boss's boss is the individual who provided the new authorization number.

5 March 1998
Received letter from Laura Gill confirming that payment for October 30 and November 11 was denied. Received EOB for December 18 showing payment authorized, but not listing my cost share. This means I have to contact the Austin office again to get them to correct the EOB so I can file for Champus supplement insurance reimbursement. (See Attachment N)
At the same time, I have been dealing with a bill for care for my daughter Jennifer from our time in Belgium. I received an EOB which I thought showed payment to Ambroise Pare Hospital. However, the hospital billed again saying payment had not been received. I contacted Ms. Denise Labbe, Tricare representative at the SHAPE clinic in Mons, Belgium and asked for her assistance. She responded:

Good morning! Sorry for the delay, but I needed input from Ambroise PARE Hospital first. Mrs Deleau, from the billing department in Ambroise Pare has one outstanding bill in the amount of BF 587 for care rendered to your daughter on 4 June 97. They did not receive/find a cheque from CHAMPUS. I called WPS to get a copy of the EOB, but they told me that the claim had been forwarded to Region 6 (Texas) for processing as patient had a stateside address and they gave me the phone number of the HBA (608 2432626) for assistance.
When I have a problem like this I normally give a copy of the EOB to the provider and ask them to give me a statement that they did not receive the check issued by CHAMPUS. Both documents are then returned to CHAMPUS for tracer action on the cheque and another cheque is issued if appropriate.
Can you give me the "check number" info that is on the EOB and verify if the "paid to" is Ambroise Pare (they sometimes paid the wrong provider). You may of course send/fax me a copy of the EOB but that may not be very convenient for you (fax 0032-65-445882). I already obtained a copy of the bill from Ambroise Pare and you gave me the claim number.
Have a good day! Hope to hear from you soon.

I re-examined the EOB and discovered that Tricare had not paid the hospital, but had claimed the entire amount as part of the patient deductible. My understanding was that 100% of care overseas was covered, as it had been in my cancer treatment.

From Denise Labbe:
March 9
I sent you a message last week but got no confirmation from the system it got through, so I am sending it again. Disregard if you already received it.

WPS-CHAMPUS recommended that you contact Region VI to correct your file. You basically need to give them the claim number and let them know that you were living overseas at the time the care was received.
Once the file is corrected, WPS in Madison WI can accept the claim and pay the bill. They need a copy of the bill, claim form with your old Belgium address and a copy of the corrected EOB. As you have to fill out another claim form they think it would be easier if you send in the paperwork. Here is their address: Foreign claims, WPS-CHAMPUS, P.O. BOX 8976, MADISON, WI 53708-8976.
They also asked me to inform you that according to their screen you are not enrolled in Region VI. If you want to be enrolled in Region VI you may need to look into this. Enrollment in Region VI can only be done by Region VI. Hope this will help you.
Thank you for giving me your e-mail address. This definitely improves communication and makes problem solving a lot easier.
Denise.

How incredible that Region VI doesn't know the Glacel family is enrolled after all the phone calls, paperwork, complaints and referrals we have been through for the last eight months!

12 March 1998
Spoke with Laura Gill today after trying for 5 hours to reach Austin. The December 18 payment was authorized under standard Champus, and thus the amount was considered as part of my deductible. The record will have to be revised. No more EOBs are available because claims are still "in process." No record of re-billing for October 30 and November 11. The claim for the prosthesis is in process and they have received my information. They called Dell's Bra Boutique to get a Tax ID number.
I mentioned to her the problem with Jenn's claim from Belgium. Laura was very helpful and called Foreign Claims in Wisconsin. Turns out that since Jenn was not registered for Tricare that she was ineligible to get the treatment in Belgium. I explained that as a university student in VA, she had no Tricare option available. No Tricare contract has been let there. Seems that doesn't matter. If she got care, she was still considered Tricare Standard and the treatment in Belgium went toward her deductible.
I have re-sent the paperwork to Foreign Claims as Denise suggested. At the same time, I am arranging for payment in Belgium so the hospital is not out its fair payment.

Physical Therapy appointments:
March
2
6
10
12
30

1 April 1998
After being away for two weeks, I was re-evaluated in physical therapy and had retained range of motion, in fact gained a bit. That is a good sign that I am finally progressing on my own.
I called Tricare again to request EOBs for Oct 30, Nov 11, Dec 18 and everything since January 22. I was told they would be sent out the next day.

6 April 1998
I received a note from E Pintz, BSR at Foundation stating that the system does not have claims for prescriptions on the dates I requested. I never asked for anything having to do with prescriptions. (See Attachment O)

8 April 1998
After trying for several days to reach a person, I finally spoke to a male BSR somewhere in the Foundation system. I explained the previous problem for requesting EOBS. He checked my record and said that Oct 30 and Nov 11 were still denied because an unauthorized provider was listed. The Peno Carter Clinic had informed me that they had re-billed for these dates. The BSR will send out EOBs for Dec 18 and dates since January 22 that have been completed. He can not send out EOBs on dates in process.

9 April 1998
I requested that the Carter Clinic re-bill the Oct 30 and Nov 11 dates again. The medical records clearly state that Peno Carter, an authorized physical therapist performed the treatment, yet Foundation persists in denying the claim saying that the p.t. assistant's name is on the record.
I have achieved nearly 100% range of motion in all fields except for internal rotation. We have agreed that I will sit out of physical therapy for three to four weeks to see if I can maintain range of motion without treatment. I will be re-evaluated in early May.

16 April 1998
Received EOBs today but the ones for Jan 22 and March 10 are missing. That means I will have to call again. I have put together all the paperwork for Oct 30 and Nov 11 to prove that my medical records state that Peno Carter provided my treatment on those dates. I will send an appeal to Foundation who have twice denied payment. Interesting that they state on the EOB that one should follow the procedure on the reverse of the EOB, yet nothing is printed on the reverse.

A

6795 Patton Drive
Fort Hood, TX 76544
April 16, 1998

Foundation Health Federal Services, Inc.
P.O. Box 8997
Madison, WI 53708-8997

To Whom It May Concern:

Since February 12, I have been trying to correct a Foundation error in billing by working through the BSRs in Austin, Texas. I have had no success, so I am now writing to you. The error dates from services provided on October 30 and November 11, 1997. I first requested Explanation of Benefits on February 12. I received statements dated February 25 which first alerted me to the error. Your statement tells me to follow procedures on the reverse of the EOB. Please be aware that nothing is printed on the reverse of any EOB I have received.

I have talked to numerous BSRs in Austin and in Wisconsin without resolution of this error. My provider has re-billed Foundation for the dates in question, still without resolution. Your records show that my physical therapy treatments on October 30 and November 11 were performed by a physical therapy assistant. My medical records from those visits clearly state that Peno Carter, the registered physical therapist and approved Tricare provider performed the service. Copies of those records are enclosed.

Please correct your records and issue my EOBs so that I can collect my $12 per visit cost share from my Champus Supplemental Insurance Policy.

Sincerely,

Barbara Pate Glacel
206-38-8719

Enclosures

Physical Therapy appointments:
April
1
6
9

B

FOUNDATION HEALTH
FEDERAL SERVICES, INC

GLACEL,BARBARA,P

6795 PATTON DRIVE
KILLEEN TX 76544-1343

DATE: 11/21/97
SPONSOR: 206388719
ICN NO: 97311 48 18426 9
CLMS NK7 L1001 TU

RE: GLACEL,BARBARA,P

"Please note those items below and return the necessary information together with this form within 15 days. Please do not attach any new charges or claims."

In order to process your claim for E0730-TENS UNIT we need the following documentation:

- Is the equipment available for loan from a Uniformed Services Medical Treatment Facility?

IF YES, WHY WAS EQUIPMENT NOT OBTAINED FROM MILITARY TREATMENT FACILITY?

Thank you for your cooperation,

NK7
FHFS-CHAMPUS

Reminder: If we do not receive the requested information within 35 days, your claim will be denied. If this occurs, you must submit the requested information by December 31 of the year following the date of service (for dates of service prior to 1/1/94) or 90 days from the date of our first request, whichever is greater.

For dates of service on and after 1/1/94, the requested information must be submitted no later than one year from the date of service/ discharge or 90 days from the date of our first request, whichever is greater.

C

Range of Motion of Right L. ...der of Barbara Gilbert

Date	1/28/97	2/3/97	6/1/97	7/4/97	8/12/97	9/11/97	10/7/97	10/9/97	10/17/97	11/1/97	12/16/97	1/14/98	2/19/98	GOAL
Provider	Maria Jorio	Maria Jorio	Maria Jorio	Maria Jorio	Pena Cartel	Pena Cartel	Pena Cartel	Dr. Grant	Pena Cartel	Pena Cartel	Pena Cartel	Dr. Grant	Shelley Kosel	
Position	supine	supine	supine	supine	supine	supine	sitting	supine	supine	supine	supine	supine	supine	
Abduction	70	85	70	85	110	145	145	170	190	160	170	180	185	180
Flexion	95	105	90	135	115	160	145	160	170	175	175	170	155	160
Internal Rotation			50	65	35	80	85	50	65	75	75	60	70	80
External Rotation			5	40	45	65	70	70	85	70	85	80	100	120
Extension					30	35	40		45	70	75			
Adduction					20	45	25		30	45	75			

	Post-Surgery	Pre-Chemo Therapy	Post-Chemo Therapy	Release from Belgium Treatment	Begin Treatment in Texas	ROM in supine position is better than sitting	Orthopedic evaluation
				No Physical Therapy for one month during move to Fort Hood			

February 1998

APR-23-98 THU 19:35 VIMA BELGIUM 3265335514 P.04

027 RPT AREA: 012 - Claims Res - R6 ICN: 9803614682-3 ROUTE TO: 027

REFERRAL FOR CIVILIAN MEDICAL CARE

SUBMIT CHARGES TO: ☐ REFERRING UNIFORMED SERVICES FACILITY ☐ CHAMPUS

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM (Requesting physician or service)	DATE OF REQUEST
MC	[illegible]	12-3-97

REASON FOR REQUEST (Include any pertinent findings)

Hx of S/p mastectomy --

Need: Bra + prosthesis

ANTICIPATED LENGTH OF TREATMENT

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
Cathy C. Ortenzio, LTC, USA, MC 173-48-0427 Chief, Dept. of Surgery Darnall USA Comm. Hosp., Ft Hood, Tx	*	☐ OUTSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

PRIME

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO	ORGANIZATION	REGISTER NO	WARD NO

PATIENT'S IDENTIFICATION (If a typed or written name is used, Name - last, first, middle, grade, rank, rate, hospital or medical facility)

DD FORM 1 OCT 76 2161

GLACEL, BARBARA P

30/206-38-8719

PATIENT RESPONSIBLE FAMILY MEMBER SIGNATURE

SPONSOR'S FULL REGN AREA: 012 - Claims Res - R6 ICN: 9803614682-3 ROUTE TO: 027

IMPORTANT INFORMATION (on reverse side)

E

FOUNDATION HEALTH
MEDAS SERVICES INC

GLACEL,BARBARA,P

6795 PATTON DRIVE
FORT HOOD TX 76544-1343

DATE: 02/16/98
SPONSOR: 206388719
ICN NO: 98036 51 14682 3
CLMS NH3 L0101 TU

RE: GLACEL,BARBARA,P

"Please note those items below and return the necessary information together with this form within 15 days. Please do not attach any new charges or claims."

- Diagnosis - list of symptoms/nature of illness or injury. Breast Cancer - Mastectomy

ALSO, PLEASE VERIFY THE SUPPLIES PURCHASED. See Receipt

Your cooperation in this matter is appreciated.

Sincerely,

FHFS-CHAMPUS

Reminder: If we do not receive the requested information within 35 days, your claim will be denied. If this occurs, you must submit the requested information by December 31 of the year following the date of service (for dates of service prior to 1/1/94) or 90 days from the from the date of our first request, whichever is greater.

For Dates of Service on and after 1/1/94, the requested information must be submitted no later than one year from the date of service/ discharge or 90 days from the date of our first request, whichever is greater.

F

CARTER
PHYSICAL
THERAPY

Peno Carter, P.T.

To whom it may concern:

BARBARA GLACEL

2-10-98 Patient received electrical stimulation to the right shoulder x 20 minutes followed with therapeutic exercise x 30 minutes and ice massage to the right shoulder.

ASSESSMENT: Patient has been in Virginia the past 2 weeks. She has been performing the range of motion exercises with the assistance of her husband and on her own. Ms. Glacel was questioning why it was stretching so much more when we were doing PROM today. I explained that there are many little details involved in passive range of motion and even though many patients and others believe that any type of exercise will suffice, the little details are what makes the difference. In addition, we talked and Ms. Glacel made the comment that she had started with her chemotherapy and other therapies after surgery but those therapies were primarily to maintain her status. I explained that realistically she was probably not maintaining status quo with the shoulder. In fact over the six months that she was receiving chemotherapy and other therapies, the shoulder was more than likely in a declining situation becoming more stiff and more adhered so that when we were finally able to start physical therapy we were starting at a level lower than she was immediately after surgery. This is one of the reasons that we have had ongoing difficulties attaining full range of motion and holding full range of motion. Overall, Ms. Glacel has made progress with the physical therapy and the passive range of motion and other treatments that we are doing. Due to the training we get as physical therapists, we are aware of many little details and shortcuts that help provide results and even with proper home program training there are still things that are difficult to explain since the average layperson does not have the benefit of six years of extensive anatomy, physiology and other course work that is required to be a physical therapist.

If you have any questions or concerns about the above, please contact me at (254) 634-3764.

Thank you for this referral.

Sincerely,

Peno Carter, P.T.
PC/gj

1713 S.W. HK Dodgen Loop
Suite 122
Temple, Texas 76502
(254) 742-1303

2123 South Clear Creek Road
Killeen, Texas 76542
(254) 634-3764

G

CARTER
PHYSICAL
THERAPY

Peno Carter, P.T.

February 19, 1998

From: Shelley V. Kozel, P.T.
RE: Barbara Glacel

To whom it may concern:

Ms. Glacel has 10 degrees less external rotation and 20 degrees less internal rotation in her right shoulder than her left. Her right pectoral muscles are weak. As compensation for limited scapular motions, she has anterior subluxation of her right glenohumeral joint. This has stretched the anterior joint capsule along with the rotator cuff tendons. The long-term effect of this compensation is rotator cuff injury and damage to the tendon of the long head of the biceps. Positioning for optimal stretch of the pectoral muscles and re-training appropriate muscle function are very complex activities. Ms. Glacel requires skilled therapy to attain full pain-free function of her right shoulder and to avoid damage to the rotator cuff and biceps.

If you have any questions or concerns about the above, please call (254) 634-3764.

Respectfully,

Shelley V. Kozel PT, PCS

Shelley V. Kozel, P.T.
SK/lm

1713 S.W. HK Dodgen Loop
Suite 122
Temple, Texas 76502
(254) 742-1303

2123 South Clear Creek Road
Killeen, Texas 76542
(254) 634-3764

H

BARBARA GLACEL

10-20-97 Patient received electrical stimulation to the right shoulder x 20 minutes followed by performing therapeutic exercises to include PROM and AROM exercises x 30 minutes. Afterwards, patient received ice massage to the right shoulder.

Peno Carter, P.T.
PC/ah

BARBARA GLACEL

10-22-97 Patient received electrical stimulation x 20 minutes to the right shoulder followed by performing therapeutic exercises to include PROM x 30 minutes. Patient was unable to stay for AROM and strengthening exercises. After exercises patient received cold pack x 15 minutes.

Peno Carter, P.T.
PC/ah

BARBARA GLACEL

10-30-97 Patient received electrical stimulation to the right shoulder x 20 minutes followed by performing therapeutic exercises x 30 minutes to include hands on PROM with contract/relax. Afterwards, patient received ice massage to the right shoulder.

ASSESSMENT: Patient missed a couple of treatments due to being out of town on business. We will attempt to make these up at her convenience.

Peno Carter, P.T.
PC/ah

I

CARTER
PHYSICAL
THERAPY

Peno Carter, P.T.

PHYSICAL THERAPY RE-EVALUATION

BARBARA GLACEL

11-11-97

Patient received electrical stimulation to the right shoulder x 20 minutes followed by performing therapeutic exercises x 45 minutes to include PROM and AROM for the right shoulder. Afterwards, patient received ice massage to the right shoulder.

AROM: *RIGHT SHOULDER*

Flexion 175 degrees	*Extension 70 degrees*
Abduction160 degrees	*Adduction 45 degrees*
Internal rotation 75 degrees	*External rotation 70 degrees*

ASSESSMENT: Patient is doing better. She is making improvements with her ROM. Ms. Glacel still complains of pain into the right shoulder with certain movements and activities. She has made good progress with AROM though the complaints of pain could result in difficulties later on during her home program. We discussed this with Ms. Glacel and we both feel that it would be beneficial to continue with physical therapy x 4 more weeks. There are several reasons for this. First, Ms. Glacel is still having quite a bit of pain with movements. Second, she still does not have full ROM though she has functional ROM. Finally, with the holiday season being upon us, my concern is that Ms. Glacel may get sidetracked and not be as dedicated to her home program as she should be resulting in loss of function and ROM. For these reasons, I request an additional 4 weeks of treatment to be spread over the holiday season. Ms. Glacel will be out of town for about ten days over Thanksgiving. With this taken into consideration, 8 more visits would extend approximately to the week of Christmas.

If you have any questions or concerns regarding the above, please contact me at (254) 634-3764.

Thank you very much for this referral.

Sincerely,

Peno Carter, P.T.
PC/ah

1713 S.W. HK Dodgen Loop
Suite 122
Temple, Texas 76502
(817) 773-0461

2123 South Clear Creek Road
Killeen, Texas 76542
(817) 634-3443

J

FOUNDATION HEALTH
FEDERAL SERVICES, INC

February 25, 1998

Barbara P. Glacel
6795 Patton Drive
Fort Hood, TX 76544

Sponsor #: 206388719
Patient : Barbara P. Glacel
Claim # : 97330 48 11217
Dates of Service: 10-30-1997 - 10-31-1997
Carter Physical Therapy

Dear Mrs. Glacel:

This is in reply to your recent inquiry. I hope the following information will be helpful.

We processed your claim on 12-04-1997. Your claim was denied because the provider is not CHAMPUS authorized for these services. These services were provided by a physical therapist assistant. Physical therapist assistants are not payable under CHAMPUS policy. This charge will therefore remain denied.

Please contact us if we can be of further assistance.

Sincerely,

Laura Gill
Beneficiary Service Representative
Austin CHAMPUS Tricare Service Center

K

CHAMPUS/CHAMPVA SUMMARY PAYMENT VOUCHER 700 115 3 430
TRICARE Southwest - CHAMPUS

dr stored by: FHFS, Inc.
.. Box 8997
adison, WI 53708-8997

1810
02/25/98 ** DUPLICATE COPY **
PAGE 1

765441343 3
BARBARA P GLACEL
6795 PATTON DRIVE
FORT HOOD TX 76544-1343

CARTER PHYSICAL THERAPY
12/04/97

SPONSOR NO 206388719
PATIENT ACC # 00000000000002454
SPONSOR ROBERT GLACEL

PATIENT NAME	CLAIM NO
BARBARA P GLACEL	1997330 48 11217

PROVIDER	SERVICE DATES	PROCED	MOD	NO	TYP	BILLED	ALLOWED	CODE
PACE LINDA PTA	10/30/97-10/31/97	97110		02	01	50.00	0.00	018
PACE LINDA PTA	10/30/97-10/31/97	97032		01	01	20.00	0.00	018
PACE LINDA PTA	10/30/97-10/31/97	97039		01	01	25.00	0.00	018
					TOTAL	95.00	0.00	

	DEDUCT	OTHER INS. PAID	COST SHARE	PAID BY PATIENT	TOTAL PAYABLE	NET PAYMENT
**	0.00	0.00	0.00	0.00	0.00	0.00

REMARKS
$284.83 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF $1,000.00 FOR THE FISCAL YEAR '98.
ACCUMULATED INDIVIDUAL DEDUCTIBLE FOR FISCAL YEAR '98 IS $68.83
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '98 IS $68.83
CODE 018 PROVIDER NOT CHAMPUS AUTHORIZED FOR THIS SERVICE. SEE ITEM FOUR ON REVERSE OF PAGE 1.

L

February 25, 1998

Barbara P. Glacel
6795 Patton Drive
Fort Hood, TX 76544

Sponsor #: 206388719
Patient : Barbara P. Glacel
Claim # : 97330 48 11218
Dates of Service: 11-11-1997 - 11-11-1997
Carter Physical Therapy

Dear Mrs. Glacel:

This is in reply to your recent inquiry. I hope the following information will be helpful.

We processed your claim on 12-04-1997. Your claim was denied because the provider is not CHAMPUS authorized for these services. These services were provided by a physical therapist assistant. Physical therapist assistants are not payable under CHAMPUS policy. This charge will therefore remain denied.

Please contact us if we can be of further assistance.

Sincerely,

Laura Gill
Beneficiary Service Representative
Austin CHAMPUS Tricare Service Center

Send Replies to: P.O. BOX 8997, Madison, WI 53708-8997

M

CHAMPUS/CHAMPVA SUMMARY PAYMENT VOUCHER 700 115 3 430
TRICARE Southwest - CHAMPUS

d istered by: FHFS, Inc.
. Box 8997
adison, WI 53708-8997

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CONTINUED FROM PAGE 1
PAGE 2

BARBARA P GLACEL
6795 PATTON DRIVE
FORT HOOD TX 76544-1343

CARTER PHYSICAL THERAPY
12/04/97

SPONSOR NO 206388719
PATIENT ACC # 00000000000002454
SPONSOR ROBERT GLACEL

PATIENT NAME	CLAIM NO
BARBARA P GLACEL	1997330 48 11218

PROVIDER	SERVICE DATES	PROCED	MOD	NO	TYP	BILLED	ALLOWED	CODE
PACE LINDA PTA	11/11/97-11/11/97	97110		03	01	75.00	0.00	018
PACE LINDA PTA	11/11/97-11/11/97	97032		01	01	20.00	0.00	018
PACE LINDA PTA	11/11/97-11/11/97	97039		01	01	25.00	0.00	018
					TOTAL	120.00	0.00	

	DEDUCT	OTHER INS. PAID	COST SHARE	PAID BY PATIENT	TOTAL PAYABLE	NET PAYMENT
##	0.00	0.00	0.00	0.00	0.00	0.00

REMARKS
$284.83 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF $1,000.00 FOR THE FISCAL YEAR '98.
ACCUMULATED INDIVIDUAL DEDUCTIBLE FOR FISCAL YEAR '98 IS $68.83
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '98 IS $68.83
CODE 018 PROVIDER NOT CHAMPUS AUTHORIZED FOR THIS SERVICE. SEE ITEM FOUR ON REVERSE OF PAGE 1.

BENEFIT SUMMARY

TOTAL PAYABLE	NET PAYMENT
0.00	0.00

N

CHAMPUS/CHAMPVA SUMMARY PAYMENT VOUCHER 700 115 3 430
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Madison, WI 53708-8997

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PAGE 1

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BARBARA P GLACEL
4795 PATTON DRIVE
FORT HOOD TX 76544-1343

CARTER PHYSICAL THERAPY
02/18/98

SPONSOR NO 206388719
PATIENT ACC # 00088000000002454
SPONSOR ROBERT GLACEL

PATIENT NAME	CLAIM NO
BARBARA P GLACEL	1998012 48 11615

PROVIDER	SERVICE DATES	PROCED	MOD	NO	TYP	BILLED	ALLOWED	CODE
CARTER PENO LPT	12/18/97-12/18/97	97110		03	01	75.00	46.50	225
CARTER PENO LPT	12/18/97-12/18/97	97032		01	01	20.00	10.32	225
CARTER PENO LPT	12/18/97-12/18/97	95851		01	01	45.00	12.01	045
			TOTAL			140.00	68.83	

	DEDUCT	OTHER INS. PAID	COST SHARE	PAID BY PATIENT	TOTAL PAYABLE	NET PAYMENT
**	68.83	0.00	0.00	0.00	0.00	0.00

REMARKS
$284.83 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF $1,000.00 FOR THE FISCAL YEAR '98.
ACCUMULATED INDIVIDUAL DEDUCTIBLE FOR FISCAL YEAR '98 IS $68.83
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '98 IS $68.83
CODE 225 CHAMPUS HAS MANDATED PAYMENT LEVEL REDUCTION BECAUSE REQUIRED PREAUTHORIZATION WAS NOT OBTAINED.
CODE 045 APPLIED TO DEDUCTIBLE. SEE ITEM SIX ON REVERSE OF PAGE 1.

********** BENEFIT SUMMARY **********

TOTAL PAYABLE	NET PAYMENT
0.00	0.00

FOUNDATION HEALTH
FEDERAL SERVICES INC

Date 4-2-98

To: Barbara Blasek
6795 Patton Dr.
Ft. Hood, Texas 76544

In Response to your recent inquiry: _____

____ EOBs you requested are enclosed.

____ Information you requested is enclosed.
___Enrollment Package

___Directory ___Benefit Handbook ___Application ___Change Form

___Claim Forms ___Other Health Insurance Questionaire

✓ Other:: The prescription explanation of benefits you requested for 10/30/97, 11/11/97, 12/18/97 are not showing in the system, so I am unable to order the EOB's. Also there are none showing in the system for any prescriptions in 1998. Please contact your pharmacist and have them check to see if the prescriptions were run on different dates. If not, call us back with all the prescription numbers and we can try and research for you.

Sincerely,

_____, BSR
Austin TRICARE Service Center
1-800-406-2832 (Option 3, Option 1)

Mr. MICA. Thank you for your testimony. Without objection, since it's so well written and documented, I'm going to ask unanimous consent that we do include your entire statement in the record.

Now we're going to hear from another individual who's had to wrestle with this so-called system of health care.

The chair recognizes Mr. Boyd Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman, Mr. Cummings. As a retired enlisted man, I'm a little nervous here. I'm not a little nervous because I'm speaking before Congress, but I'm nervous because this is such an important issue. To me, this is the same as any other emergency, as an example tornadoes in Tennessee. Not to belittle those events, but people are dying, and it would be interesting to know how many have died within the last 2½ years while waiting to get the promised health care.

You see, my son is a serving officer in the U.S. Army, he is a company commander. And on January 16th, while he was serving on the DMZ in Korea, his mother was turned away in an emergency.

If you can imagine breathing through a straw for nearly 9 months, and that's how bad her tracheal stenosis was, later the physicians couldn't get a 6-millimeter tube down her trechea. She was bounced between the VA Hospital and Eisenhower Army Medical Facility, SWA Hospital in Augusta. And on the night of the emergency—well, I knew it was really a serious problem—I refused to leave the VA medical facility until she received treatment.

The county sheriff was called, two deputies came in, and I had to leave. So I took my wife out to Eisenhower Army Hospital, where she was admitted but they had no medical records, no baseline. She had been treated off and on episodically for the past 3 years at the Veterans Administration Hospital. So she spent the night at Eisenhower in pain and was transferred back the next morning to the VA Hospital, where she was put in a room and still no care was provided.

I contacted her neurosurgeon at the Medical College of Georgia, who performed her initial surgery and expressed my concern and my reasons. He sent over two neurosurgery residents to check on my wife immediately after I had called him. And a short time later, she was put in intensive care and I was informed by her neurosurgeon that my wife could have died because of respiratory distress, and she was at that point when they saw her.

Now, as a result of that incident, I became an activist, and I contacted a local NBC affiliate and got their investigative reporter to do a story on it. Now, he did a pretty good job on the story. He didn't get all the issues because they were too complex, but the net result of that story was an EWT physician at the Medical College of Georgia learned of my wife's problem. He came over to the VA Hospital, saw us and offered to take care of her problem. He lasered out the tracheal stenosis, injected steroids. She's not been back in the hospital on an emergency since then. Prior to that it was almost a weekly emergency.

My point is choice is critical. In FEHB you have a choice of provider. You have a choice of the facility. In TRICARE, VA, and these other programs, you don't have a choice. If the person you're seeing is incompetent, that's your problem, you're stuck.

Choice is critical. Now a couple of other issues. I keep hearing about readiness, which in my mind is a red herring, and I keep hearing about a lack of money, and let me tell you why I think readiness is a red herring. If readiness is so important, why was my wife turned away in an emergency while her son was serving on the DMZ in Korea. After he learned of that, you can bet he was not too happy about military health care.

Another point is, why are retirees turned away when we go to the military medical facilities? Now you say you can be seen on a space available basis; in fact, that's not true. The only way you would be seen is in acute care emergency. You cannot get an appointment, unless you're a member of TRICARE prime.

Now we're already paying for Medicare, Part A and Part B. And if we did go into TRICARE prime, it would cost us more than what we're paying in Medicare. I don't know what Medicare covers and what it doesn't cover. You have enough stress on you when you're trying to deal with these catastrophic problems without all these bills coming in.

But another question that comes up is why are recently retired veterans who are eligible for recall a lower priority than an active duty dependent, if readiness is an issue. Can physicians be trained in trauma centers where the injuries presented would more closely resemble combat injuries? Doesn't the VA have a shortage of physicians where military physicians could be trained.

And haven't we sacrificed enough; with our years in the military, overseas assignments, living in conditions where you can't place a felon, and now we're being asked to sacrifice further for readiness?

The only way readiness pertains to us is when DOD needs our body count to get the money in the budget. But they really don't want to provide the health care.

The second issue is lack of money. And I'll give you an example here. I keep hearing about 1.3 million Medicare eligible retirees who are potential beneficiaries, and GAO in a report last month said that 70 percent of those would probably elect FEHBP. We only have 1.8 million retirees; all you have to do is go look at the defense finance and accounting (DFAS) web site to learn that there are 1.8 million people drawing retirement checks. Of those, about 400,000 are Medicare eligible.

Now, when you pay for—when the government pays their portion of the FEHBP, they're paying 1 of 2 premiums, $1,600 for a single member, or up to $3,600 for a family. But when you talk about 1.3 million beneficiaries it exaggerates the problem. There are only 1.8 million DOD retirees. In FEHBP, you have a choice of a family plan or a single plan, not a per beneficiary plan. So when we hear numbers like 8 million, we're really talking about the 1.8 million. And when you subtract out the nearly 200,000 who are—who are employed now in civil service, who are already eligible for FEHBP, the number gets even smaller.

What I wound up having to do is selling my home. I sold all of my furniture. We're now living in a motor home in San Antonio, TX. Just so I can get into the FEHB Program, I took a Government job and moved to San Antonio. I have FEHBP now. It's eased a lot of my concern on being able to provide health care for my wife. So

FEHBP is kind of a moot point for me while I am employed by the Federal Government.

But what really bothers me is when I see these reports OPM, the Office of Personnel Management, cannot tell GAO how many people are retired military. If you go to the 1997 OPM fact book, it clearly shows that 4.3 percent of all the civilian employees are military retirees.

Now, as far as not being able to estimate the cost, if I can turn on the TV at 6 o'clock during a Presidential election and find out who's going to win the next election even before I get a chance to get to the polls, I find it hard to believe that you can't look at those 1.7 million civil service retirees who are in the FEHB Program and use them as a data source for the empirical data that you need to calculate what it would cost to provide for those 1—actually less than 1.8 million military retirees.

DOD received roughly $15.7 million in 1997—1996 for health care. FEHBP was $16.6 billion. Now, they traded—FEHBP covered between 9 and 10 million beneficiaries, and DOD had responsibility for a little over 7 million, which include retirees who have difficulty being seen to get the care. DOD and FEHBP both spent roughly $2,000 per beneficiary.

Now, Medicare during the same period spent $214 billion plus $98.5 billion for Medicaid, and that's roughly $6,000 per beneficiary. It looks to me like FEHBP is a pretty good program. FEHBP has generally a 90 percent or a higher customer satisfaction rate. The most popular plan in FEHBP has a catastrophic cap of $2,000; pays 100 percent of the inpatient care; 95 percent of the outpatient care; 95 percent of the tests. And I don't know of any physicians looking for reasons to turn away Blue Cross and Blue Shield patients.

Now, for my part the bottom line is health care is a life and death issue. Choice of hospitals and providers are the most important aspect of health care. The title MD does not make a physician; experience, current knowledge, dedication, and the health care facility make for the good physician. Physicians want to practice medicine, not fill out HCFA 1500's and argue about denied claims.

Any organization that stands before you and tells you that as enlisted folks we can't afford FEHBP or makes any other such misrepresentation, I would suspect a conflict of interest or a hidden agenda. As an enlisted man, I couldn't afford not to have FEHBP. I know my costs now, and on my meager $14,000 a year retirement, I can still provide care for my wife and survive.

And in closing, anything less than full membership in FEHBP, along with the rest of the civil service retirees, I don't know how we became a lower or class status than the typical government employee. As a matter of fact, I understand postal workers have their health care subsidized even further. But I think it's a national disgrace and an insult to the men and women who paid and still pay in blood for the freedoms enjoyed in this country as you turn us away from health care and refuse to treat us as an equal in the Federal Government health care system.

The only fair way is as a full and equal partner in FEHBP. And I don't believe that it'll cost any more money. In fact, DOD says that we're 54 percent of their health care obligation. For just 13 percent of their budget, they could be rid of us. So why don't they?

Thank you, sir.

[The prepared statement of Mr. Simmons follows:]

Summary

I am Boyd W. Simmons, MSG, USA, Honorably retired after 20 years service. Prior to my retirement, Lucy Simmons my loving wife of 30 years, and I were enrolled in family practice at Eisenhower Army Medical Center. After retirement in 1985 we went about the process of starting and building a business confident that we would continue to receive comprehensive medical care should we need it.

In 1993 Lucy required critical surgery. Eisenhower Army Hospital looked to the Veterans Administration hospital to provide the complex brain surgery. The VA provided the surgery and then wanted to quickly transfer Lucy's care back to the Eisenhower Army medical facility where she would be treated on a space-available basis.

At a Department of Defense facility the only medical care available for someone like Lucy Simmons would be on a "space-available" basis. Do you know what "space-available" means in the real world? Can you imagine a helpless, child-like, traumatic brain-damaged, paralyzed, and incontinent adult female? Forced to sit quietly in a waiting room for hours or even days at a time? Only to be finally told to "come back tomorrow" because there is no "space-available" today?

Since the bureaucracy at Eisenhower Army Hospital and the Veterans Administration effectively abandoned her care, Lucy Simmons has not only been refused basic medical care, she has been refused emergency treatment. She has been bounced from one facility to another because no one in charge wanted to be bothered or to have to accept responsibility for her medical care. Lucy has even been threatened with arrest when her husband tried to obtain treatment for her. As a result her physical health deteriorated.

Episodic, slapdash medical care, bureaucratic medical management (and mis-management) processes, and the whole uncaring system's insensitivity to the needs of the patients it supposedly is there to serve have caused Lucy, my children, and myself an untold amount of psychological, emotional, physical, financial suffering and hardship.

During the two year period immediately following her brain surgery, it seemed as if Lucy and I had been left totally on our own. We went through some extremely horrible and depressing months together. The enormous medical bills kept piling up and there was no relief in sight. In-patient therapy in a non-profit rehabilitation hospital would cost over $9,000 a week. As the average pay of an enlisted military retiree is only about

$14,000 a year, this would have been an impossible situation for anyone like me. There were instances of unexplainable bureaucratic callousness that I personally will never get over or be able to forgive.

To this day, Lucy still cannot be left by herself for safety reasons and other physical disabilities. I had to sell a successful, on-going business enterprise in order to stay with her and in order to provide personal care for Lucy.

This past December we ended up selling our home and furniture. We moved to San Antonio, Texas, so that I could get a federal job which would allow me to enroll in the Federal Employees Health Benefit Program.

- · I am not here asking for free health care.

- · I am not asking for an entitlement.

- · I am not here to beg for the fulfillment of a contractual promise made to career military personnel, which was health care for life.

- · I am not asking for SPECIAL Treatment, I am merely asking to be treated as all other government employee's and allowed to participate in the same health care plan you are in. I notice postal workers have the employees share of the cost even subsidized further.

I have come to the realization that the only way Lucy and the many others like her will ever get effective and adequate medical care is through the Federal Employee Health Benefits Program. The only fair way to provide that care is to offer military retirees the same program offered to all other federal employees. Military retirees cannot afford to not have this option.

Facts bearing on the DOD health care problem:

- · Peer-to-peer relationship between separate government agenciesâ ¦ no one in charge of, or responsible for the patient's care.
- · Extreme stress on family and patient, as they are left to fend for themselves.
- · Joint venture agreements between agencies not complied with.
- · VA staff has the attitude that care provided to dependants is at the expense of other veterans.
- · No primary care provided.
- · Duplication of CAT Scans and X-rays.
- · No coordinated control of prescriptions to prevent adverse drug

interactions and reactions.

- · Drug levels not closely monitored resulting in medication overdose.
- · Denial of care decisions made by medically untrained clerical/administrative personnel.
- · Denial of care in Life Threatening Emergency made by clerical/administrative personnel.
- · Contradicting medical diagnoses and decisions.
- · Lack of communication between treating specialties and clinics.
- · Delayed treatment due to lack of coordinating authority.
- · Medical problems worsened due to the lack of timely care and stress on patient.

Conclusion:

"One may wonder why I wanted the Veterans Administration to continue to treat Lucy after what transpired. The VA was our best alternative based on available options. Lucy and I have endured and struggled to establish the level of care she has received so far, we did not want to start over with a new bureaucracy. The horror stories of our learning experiences are too numerous to list here.

The buck-passing has to stop and healthcare must become the No. 1 priority for Lucy and any others who find themselves in the same situation. It all boils down to money: neither the VA nor the DOD wants to pay for the care of a chronically ill patient. If the truth were told, had Lucy been tested for an organic problem rather than being treated in a DOD facility for depression, she would probably not be chronically ill now.

Responsibility for righting this wrong can not continue to be passed around. On this issue "the Buck stops here" for the military retiree, congress giveth and congress taketh away. Congress must restore our faith in the integrity of our government by stepping forward and providing health insurance equity for military retirees. Not the reluctantly provided, dysfunctional bureaucratically managed , episodic care systems currently in place." Please stop testing and talking while military retirees and their family members are dying. Somewhere along the way we lost the KISS principle. An application of that principle here would allow the option of the transfer of the military retiree into the FEHBP system.

If the DOD could get their financial house in order and military treatment facilities (MTF) were allowed to bill the medical insurance carrier, I believe most retirees living within the catchment area's of MTF's would continue to use those facilities, itâ ™s the only life they have ever known.

Most military retirees still trust in the system that has disenfranchised them. Those who have a continuing need or those who are more strategic in their thinking should realize the covenant of health care will not be honored. FEHBP is popular among federal employees, point in fact the Office of Personnel Management fact books show an over 90% approval rating.

I would like to thank my former Congressman Charlie Norwood , and my former Senator Paul Coverdale for taking a stand along with Congressman Mica and Congressman J.C. Watts in support of FEHBP as an option for all military retirees. If I am able to obtain an audience, I hope to visit with both Senator Hutchison and Senator Gramm on my return to Texas to brief them on data I have compiled. I would like to demonstrate the cost savings by offering FEHBP as an option to military retirees. I am so weary of hearing the government cannot afford to provide the health care we were promised. We can find funds to place soldiers in harms way for almost any purpose, we can find funds, 22 billion, to provide daycare for children, Lucy Simmons raised our two children, you see I was frequently overseas and not available to help. I am positive FEHBP can be offered at NO ADDITIONAL COST, but if it should be at a cost, its merely a deferred payment of the $5000.00 per year in medical benefits we were shown each year on our annual compensation worksheets.

In closing a brief example, of the most important reason we need FEHBP. Lucy suffered for 10 months after her last surgery in July 1996, because of severe tracheal stenosis, in addition to a toxic medication overdose. Purely by chance a caring physician learned of her plight and offered assistance. The procedure he performed has kept her out of the hospital for over a year now. Meanwhile she is still today turned away at military medical facilities. FEHBP gives the patient a chance at finding and affording the right physician and the right medical facility, which can mean the difference between life and death.

Supporting Details

I served in the Army for 20 years, 14 of them overseas. I bought a home in Augusta in 1982, retired .n 1985. For most of my 20 years in the Army, I was told my medical needs, and the needs of my family, would be taken care of as part of my retirement package. I endured low pay and tough conditions, including two tours of duty in Vietnam, then 15 months as an advisor to the Chinese Army on the isolated off-shore island of Matsu. Virtually years away from Lucy and children, out of a sense of duty, knowing when I finally decided to retire, I would be able to pursue our dream of business ownership, and then reap some of the benefits I worked so hard to earn and to protect.

Believing in the system I served for nearly half my life, I entrusted the medical care of Lucy and children to the military for many years. However, as a result of a series of medical misadventures, Lucy is now permanently disabled, suffering serious ongoing medical problems. And her situation is becoming worse because of continuing bureaucratic mismanagement of medical care.

After what we've been through, I could write a detailed technical manual on the subject of medical care mismanagement, but I will simply give you an idea of what we've been through. My request of you is simple: I want to assure Lucy is able to obtain comprehensive, affordable and quality medical care.

Our problems started nearly three years ago when Lucy, Ah Yueh (Lucy) , was receiving routine medical care in the Family Practice Clinic at Dwight David Eisenhower Medical Center at Fort Gordon. In 1993, Lucy, a Taiwanese native I married while on duty there in the 1960s, started complaining of headaches, hallucinations, confusion and other problems. After several visits, Lucy was referred to physchiatry by family practice where she was given an anti-depressant, Zoloft.

Lucy was a smart, beautiful, vivacious young woman who worked hard to raise our two children and support me during my career. After my retirement, she worked full time in my business and was the popular hostess at a local Chinese restaurant. Lucy was known for her kindness, her basic goodness and her gentleness.

Looking back, I realize now her medical treatment at Fort Gordon was mishandled, partly out of complacency. It seems the technicians and clerks there didn't take time to listen to her, and as a result a serious medical problem was overlooked.

In April 1994, I rushed her to the emergency room. We were preparing to have breakfast together when she started bleeding from her nose and ear. Her symptoms also included severe headache, nausea and tremors.
The physician's assistant in the ER diagnosed her problem as sinusitis and told me to take her home. I requested further testing, and the assistant told me they could schedule a CT scan in 72 hours. At that point, the PA attempted to wake Lucy to send her home and could not awaken her. She then called for the emergency room physician who immediately ordered a CT scan.

The scan revealed a large tumor. Suddenly, a simple case of sinusitis became something else, and Lucy was rushed by ambulance to the VA Medical Center for surgery. The military surgeon was on vacation, so the VA resident on duty consulted with the Chief of Neurosurgery at MCG.

Because the tumor had grown so large, the surgeons spent several hours attempting to remove it and it is a miracle she survived at all. During the lengthy surgery, Lucy suffered a stroke and lost most of her vision. She spent a month in the hospital, three weeks in a coma, and was discharged. She couldn't walk, she couldn't talk, and she could barely see, but the VA, telling me there was no physical therapy available, transferred her to a local rehabilitation hospital costing about $1,200 a day.

And that is how our nightmare began. I could write a novel here, but I won't. More than four years after first complaining of headaches and being treated for depression, Lucy is an invalid. Despite my best efforts to provide otherwise, she lives a life of pain and misery, and faces even more surgery. She was treated briefly at Walton Rehab in Augusta, Georgia after her first surgery, but left there in a wheelchair, paralyzed, half-blind, incontinent and with little hope for a life even approaching normal. And there was no provision for home care. Lucy was a victim of the system, sent home to an uncertain life because no further benefits were available.

To take care of Lucy, I sold my thriving business at a loss, shut down another promising business I had recently started, stopped development of commercially-viable software programs I had designed and written and spent literally hundreds of hours working with Lucy, teaching her to walk again, to feed herself, to bathe herself, to speak, to live a basic existence.

And Lucy, with a spirit and determination to live, spent literally hundreds of painful hours enduring the agony of this on-the-job-training therapy. We did it on our own, with very little help from the government, and Lucy is able to walk and bathe and eat and talk today only because of our sheer determination. Though she requires round-the-clock care and will never be able to be left alone, she can do some things for herself â ¦ but her nightmare is far from over and she faces even more pain and agony.
In the four years since she first reported her headaches to family practice, Lucy has endured a 22 hour operation to remove another tumor, which was even bigger than the first. She has also been through several other operations because of complications. And now she faces even more painful surgery.

This story reads like a litany of ineptitude. It would taken dozens of pages to detail it all, but here are a few of the highlights:

- · Follow-up care after her first surgery was minimal; I had to ask for a CT scan after her rehab and never even got a report back on the results. I called repeatedly asking for results and was never answered. I had to assume everything was okay.

- · In March 1996, Lucy was discharged from further care and given a clean bill of health. We were told there were no traces of the tumor.

- · As we were leaving the hospital, we bumped into the MCG surgical resident who helped with Lucy's initial surgery in 1994. We told him our good news, and he asked us when Lucy had last had an MRI.

- · When we told him she had never had an MRI, the resident took us back to the neurosurgery clinic where he consulted with the Ft. Gordon doctor on duty at the VA and ultimately demanded an MRI. This doctor, a resident on loan from MCG, had not seen Lucy in months, but he was extremely concerned that she was being discharged from care without proper testing.

- · The Ft. Gordon physician did a consult and ordered an MRI. That process took another 30 days.

- · The imaging revealed another tumor, and we were told it was small, not an emergency, and could be removed without a craniotomy. This surgery would require a team approach and she would be referred to ENT on a consult.

- · Weeks went by and I was told there was a problem with coordination of the surgery between all the departments involved. Meanwhile, Lucy started having nosebleeds.

- · I kept calling and was told that her surgery was not an emergency, and they had patients who were dying who needed priority care.

- · As her condition worsened we reported to the regularly-scheduled neurosurgery weekly clinic during the first week of April, only to find the clinic closed because the doctors were attending the Masters golf tournament.

- · A few days later, Lucy had a seizure and I rushed her to the hospital where she was admitted. Her nosebleeds continued.

- · I was told by the new neurosurgery resident assigned this time that no one had been coordinating Lucy's case. He promised to take immediate steps to see that her surgery was scheduled and team-coordinated. He felt it was crucial that the chief of Neurosurgery at MCG, who had performed Lucy's emergency surgery in 1994, be the lead surgeon. The resident did as promised and managed to get Lucy scheduled for surgery on July 2, 1996.

- · What was supposed to be a minor operation to remove a small tumor, a maxio-facial procedure, turned into much more. The doctors did a craniotomy

and extensive paranasal sinus surgery to remove the tumor and, in the process, her septum. She spent 22 hours on the operating table for this "small" tumor. Approximately 4 days later she was taken out of ICU and operated on once again to check for a possible infection of the bone flap. I learned at that time her tissue had been removed and replaced with donor tissue.

- · Lucy was in a coma, on a ventilator, for three weeks. After a month was transferred to the VA Uptown for PT and OT.

- · Lucy was discharged from the VA in early October, once again rushed out of treatment due to government financial concerns. Although Lucy was having severe breathing problems as a result of the lengthy intubation, she was discharged. Subsequently I had to return her to the life support unit due to breathing problems and she was readmitted for respiratory treatment.

- · Just before Christmas, Lucy suffered another seizure. I called an ambulance and she was taken to the VA emergency room where the various staff members and clerks on duty debated whether she should be there at all.

- · Having dealt with the system where clerks make major medical decisions, I requested an MRI. That day Lucy was taken for a CT scan, and the following day she was taken for an MRI. Once again, I was given no results.

- · While visiting Lucy a few days later, still in the dark about her condition, I ran into the military neurosurgeon, and asked him who has responsiblity for Lucy's care. He said the VA neurosurgery department has overall responsibility, but that Dr. McDonnell, the MCG surgeon who performed her first operation, was in charge. The physician remarked offhandedly that it looks like Lucy has another tumor, but that it's an ENT problem and that she had to go to ENT to see a doctor.

- · Nothing was done about the new tumor, but Lucy had an appointment Jan. 22 for laser surgery to clear scar tissue from her wind pipe. At that time the tissue which could be reached was biopsied.

I only speculate, but if Lucy had been given adequate treatment when she first complained of headaches, we might have avoided all of this. But that is only speculation.

The VA was now trying to wash their hands of Lucy's problems. The clerks at the VA and at Ft. Gordon determined that Lucy must return to Fort Gordon for treatment. I was appalled. Lucy had spent more than 40 hours in surgery at the VA. Though I have had to demand adequate care, fight for it and at times

even beg for it; though doctors have come and gone as if playing musical chairs; and even though the detailed accounting of what we have been through is horrifying, the VA was intimately familiar with Lucy's case and Dr. McDonnell, her original surgeon who saved her life after the tumor had herniated, was still there, close by at MCG, which has a sharing agreement with the VA.

The bottom line is this: no one is in charge. I have had to make people mad to get any results at all and all too often have had to beg clerks to take care of Lucy. Now, after all we've been through, I found it beyond belief that the bureaucrats were attempting to shift responsibility for her medical care to people who have never even seen her â ¦ and back to the very system that let her get this way in the first place. The physicians at the VA and MCG have documented over seven volumes of records on Lucy, the lapses have been in the follow up, and all of Lucy's current problems are associated with the original and secondary neurosurgery. Lucy needs a continuation of care for a condition previously under treatment at the Augusta VA facility.

It is long past the time for someone to step up and accept responsibility for Lucy's care. I am tired. I don't have the strength to keep begging and fighting and demanding and arguing and pleading anymore. I need some help. And all I want is that Lucy Lucy be cared for adequately with some continuity of care.

In January of 1997 Lucy's condition has taken a turn for the worse and our medical care nightmare reached a point I never believed possible. Lucy was now in an induced coma at the VA hospital, but before finally admitting her, they threw both of us out of the hospital and called the sheriff's department and threatened to have us arrested for trespassing. Please bear with me and read this story. You will be appalled.

Noticing Lucy's condition was deteriorating and that she was running a fever over 101 degrees with constant coughing, I took her to the Augusta VA Hospital on Jan. 14, 1996 where she had been scheduled for a clinic appointment by neurosurgery. Lucy had been scheduled once or twice before for appointments in the Primary Care clinic and on each occasion the appointment had been canceled without our knowledge. The resident in neurosurgery treating Lucy recognized the fact that due to the multiple surgeries, her septum being removed, and since the tumor may have reoccurred, Lucy needed coordinated follow up care.

When we arrived at the primary care clinic that day I was informed her appointment had been canceled and she was not eligible to be treated in the primary care clinic. I asked why and was told a clerk in Administrative Medical Services had called and informed the Chief of Primary Care, Dr.

Spencer, that Lucy was not authorized treatment in the Primary Care Clinic. I asked to speak to Dr. Spencer and when I did talk to him on the phone he informed me a Priscilla Bowers had contacted him to inform him of the error in scheduling Lucy for a Primary Care appointment. I explained to Dr. Spencer that all of Lucy's treatment to date had been done at the VA and due to the previous surgeries she needed a continuation of care. I told him someone had to have overall responsibility for her care to coordinate with the specialists in Neurosugery, ENT, Plastic Surgery, Endocrinology, Physical and Occupational therapy and the list goes on. I also said it was even more important she be seen at this time because she was having difficulty breathing. Dr. Spencer refused and said he did not have the resources.

At the time I was also ill and asked to be seen in Primary Care. I was seen by a Dr. Morgan, and since I have to keep Lucy with me all the time Lucy accompanied me into the doctor's office. Before looking at me, she noticed Lucy was having a problem breathing, and asked about Lucy's condition, she then left to talk to a Dr. Dupri, her supervisor. Dr. Dupri came in shortly thereafter and was concerned, but, told me the chief of the clinic had said they could not treat Lucy.

I then took Lucy downstairs to the ENT clinic where she had an appointment the next day, thinking maybe we could get in through the backdoor and get her seen right away. We waited there a couple of hours, saw the physician following her care in ENT and were told they could not see Lucy until her appointment the next day. Frustrated, we returned home.

The next morning, as I was taking Lucy to another scheduled appointment at the VA for Ambulatory Surgery work up, Lucy became incontinent, lost control of her bowels, and was suddenly unable to walk and unable to move her right hand. A nurse in Ambulatory Surgery was kind enough to help me get Lucy cleaned up and provided some pajamas, a robe and a wheel chair, she was also concerned about Lucy's breathing and recommended I take Lucy to her ENT appointment first.

At the ENT Clinic I explained my concerns that there had been a change in Lucy's condition, and she had been progressively getting worse over the last 3 to 4 weeks. What I had observed appeared to be related to neurological function. The ENT physician checked her sinuses for infection and did not find any. The ENT physician said she was concerned and would contact the Neurosurgeons and instructed me to take Lucy to the walk-in clinic to be seen.

At the walk-in clinic Lucy's temperature was 103 and she was unable to walk and she acted confused. The Walk-in Clinic physician diagnosed her problem

as flu symptoms, prescribed Tylenol and told me to take her home and give her plenty of fluids. I requested that she be admitted and that a MRI be done because she was already scheduled for an MRI on Jan. 22 anyway. The physician did not agree and we were sent home.
Later that evening Lucy's temperature had still not abated and she was having difficulty breathing. I called the Life Support Unit at the VA and informed the physician on duty Lucy had a temperature of 102 and asked at what point should I become concerned. The physician said I should be concerned now, to give her Tylenol and bring her in if the temperature has not dropped in two hours. He further stated she could not be allowed to run a 102 temperature all night. I told him I had already been giving her Tylenol but the temperature was not dropping. I gave Lucy Tylenol again and a hour and a half later her temp was at 103.9.

I then had to carry/drag her to the car to take her to the Life Support Unit at the VA. Upon arrival, the first question we were asked was "is she a veteran ?" I explained she has been treated at the VA for the past 2 Â½ years. The AOD checked the computer and informed the physician she was a JVSS and not a veteran and therefore was not eligible for care at the VA. The physician listened to her breathing and then prescribed amoxicle, Entac LA, and Robitussin. I was told then to take her home. I refused and requested she be admitted. I was told to talk to the AOD, Curtis. When I went to see Curtis he was the same person who had already informed the physician Lucy was not a Veteran and not eligible for treatment. When I explained the situation he then told me the same thing he had told the LSU physician. I became angry and began swearing, Curtis called the VA police, I explained the situation to the VA police and he told me we would have to leave. I then refused to take Lucy out of the hospital, Curtis recommended the Richmond County Sheriff be called to take Lucy home. I told the police I would take her into the waiting room to spend the rest of the night and see the VA director in the morning. He refused. The VA police said I should leave, that Lucy and I were trespassing and he then called the sheriff's department.

At that point, one of the LSU technicians recommended I take Lucy to Ft. Gordon. I asked them to call an ambulance from Fort Gordon and they refused. I called the Ft. Gordon emergency room and was told the ambulance could not be dispatched off post. As the Richmond county deputy's arrived one of the LSU technicians volunteered to help me move Lucy to my car so I could transport her to Ft. Gordon.

I took Lucy to the Ft. Gordon emergency room where she was admitted for lab tests, chest x-rays, etc. even though all of those tests had been done the day before at the VA walk-in clinic. Once the emergency room physicians checked Lucy they were concerned the problems were neurological. They said

they did not have any records on Lucy nor any history for a baseline (she had been treated at the VA for the past 2 Â½ years). The physicians at Ft. Gordon did a CT scan and saw what looked like a hematoma and discovered that her left ventricle was enlarged. They then requested Lucy be transferred to neurosurgery at the VA hospital. The emergency room started an antibiotics IV and contacted the VA. Due to the length of time it took to get approval to transfer Lucy I suspect the VA was trying to refuse the transfer.

Lucy was then taken by ambulance back to the very facility that had refused to treat her and threatened to have me arrested for trespassing. After I rejoined Lucy at the VA, I found she was being treated for flu symptoms with Tylenol and her temp was still 102 or above. At approximately 5:30 p.m. when the neurosurgeons did their rounds that day they also told me she had flu symptoms. I went through the complete explanation again on her deterioration in motor function and what had transpired at Ft. Gordon with the CT scan. The physician then asked me if the CT had been transferred with Lucy.

I asked who was following Lucy in neurosurgery and was told Dr. Lee was in charge. I asked if he had seen her yet? They did not know. It was apparent no one had checked yet to see if a neurological problem was the cause of the infection. I informed them of the CT results and that one of Lucy's pupils was dilated much larger than the other. I again requested that she have an MRI, which she was due anyway. The resident, chipped in she just had an MRI last month. The physician told me they were all following Lucy and they left. When visiting hours ended at 8 p.m. and I had to leave, Lucy still had a temp over 100 and was having difficulty breathing. Other than the nurse, no one had checked on her. Lucy was cognizant enough of her condition to be frightened.

Early the next morning I tried to contact Dr. Lee at the VA. I was told he was unavailable and I asked that he return my call. I then contacted Dr. McDonnell, Chief of Neurosurgery at MCG, and informed him of what had transpired and my reasons for being concerned about a neurological problem, Dr. McDonnell agreed that I had cause for concern and told me he was not aware that Lucy was admitted at the VA. Dr. McDonnel told me would go over and check on her condition and call me back.

Thank God for physicians like Dr. McDonnell! Within the hour, Dr. McDonnell called back and gave me a complete update on Lucy's condition. He telling me there was no bleeding and that he had compared her CT with the CT done earlier put my concerns about the CT scan at ease. What had looked like bleeding to the physicians at Ft. Gordon was from earlier surgery and not part of her current problem. Dr. McDonnell then informed me that Lucy's Dilantin level was 45, a toxic level, when it was supposed to be in the 11 to 20 range. Dr. McDonnell then informed me he would have the earlier

residents, Dr. Cowan and Dr. McDonald, check on Lucy. I was elated, both were excellent, professional and caring physicians.

Dr. Cowan called me at home later that evening and informed me he had placed Lucy in intensive care and had to intubate her, he had been unable to insert the tube completely and was using the smallest size they had a 6 mm tube. He hoped to be able to remove the tube the next morning. Dr. Cowan was concerned that either Lucy had developed pneumonia or had a blood clot in her lungs and they might have to do an arteriorgram.

Lucy was in the VA ICU (Intensive Care Unit) for two to three weeks. In my opinion, it was critical that Lucy be treated at the VA as long as she could be seen by Dr. McDonnell and his staff at MCG. To my knowledge there was no sharing agreement between Ft. Gordon and MCG.

After being forced to return to Ft. Gordon for medical care we were informed Lucy could not obtain an appointment as she was not in Tricare Prime. We were told we would have to call in on a daily basis to see if there had been a cancellation. Since Lucy had been disabled for over two years she now had Medicare and was paying for part B. I was told that if I took Lucy to a civilian facility I would not be allowed to return to the VA with her. The VA was the only facility with any medical history on Lucy.

In November of 1997, after intervention by Congressman Charlie Norwood, Lucy was referred to Wilford Hall medical center at Lackland AFB in San Antonio, Texas. The surgeons at Wilford hall did not have enough medical history to determine the size and location of the tumor and could not make a treatment recommendation. The neurosurgeon ordered an MRI and recommended I bring her back in about four months for a follow-up MRI. While in San Antonio I learned of a job vacancy at 5th Army Headquarters. I realized the only hope for Lucy was for me to get into the Federal Employees Health Benefits Program. I immediately applied for the position and on my return to Augusta, Georgia I learned I had been accepted for the position. Within one week, I sold our home and all of our furniture in a lock-stock and barrel deal. The day after closing on the sale I loaded a motorhome and moved to San Antonio, Texas. Lucy an I are now living in a motorhome and having an extremely difficult time balancing job requirements and caregiver responsibilities, and I am now paying for adult day-care and Lucy just can't understand why I have to take her to day-care.

One thing has not changed. When I attempted to obtain primary care at Brook Army Medical Center for Lucy I was told, Tricare prime only. Lucy could only be seen on a walk-in basis in acute care. We now have Medicare, and Blue Cross through FEHBP, it has eased my mind.

If I solid cost estimates can be made why aren't they:

- · There are a known number of military retirees and the number is less than 2 million.
- · DFAS could survey and calculate the number of dependents of retirees with relative ease.
- · DFAS could survey and calculate the number of retirees with employer provided health insurance.
- · OPM can with little effort obtain and calculate the number of retired military and dependents of retired military employed by the federal government and post office.
- · VA could provide the number of military retirees being treated by VA medical centers.
- · The cost of FEHBP could be reasonably calculated.
- · Cost savings to the Taxpayer would more than offset the cost of providing FEHBP.
- · Money can be found for almost any project except funding the military healthcare promise.
- · The real irony is additional money is not needed, just adequate management of the current funding.

Overlapping Health Care
1/24/98
Click here to start
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The Formula:
Recommended Action Author: Boyd W. Simmons
Email: bws@computer1.net
Home Page: http://www.computer1.net/veteran
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The recruiting advertisement below was on an Active Army Web Site until December 1997.
Judge Advocate Recruiting and Placement Service
JARAPS
Letter from the Chief, Judge Advocate Recruiting and Placement Service
Frequently Asked Questions (FAQ)
Application Procedure
U.S. Army Reserve Component Fact Sheet
Summer Intern Program
Field Screening Officers, 1995-1996

THE CASE FOR
CONSIDERING THE
ARMY JUDGE ADVOCATE
GENERAL'S CORPS
THE CASE FOR TRADITION

If you become an officer in the Judge Advocate General's Corps [JAGC], you will be joining the nations oldest law firm and one of the largest and most diversified. It is a proud organization that had its beginnings in the earliest days of our Republic.

The JAG Corps was created by George Washington on July 29, 1775, only 44 days after he took command of the Continental Army.

Since that time, the Corps growth has paralleled that of the Army Today, it is larger than any private law firm and is, in fact, the largest governmental "law firm," except for the Department of Justice. More than 1,500 judge advocates are currently serving on active duty.

The JAG Corps combines the diversity of a worldwide law firm with the camaraderie and collegial atmosphere of a small firm. Most JAGC offices range in size from three to thirty at torneys. While you will be responsible for your own caseload almost immediately, you will find colleagues and supervisors available and willing to provide guidance and assistance. The friendship and cooperation of the office extends to family members and social activities as well.

Competition for entry is keen. The qualifications are exacting and the standards are high. An applicant for a JAGC commission must have received a J.D. or LL.B. degree from an American Bar Association-approved law school and have been admitted to practice law before either a federal court or the highest court of any state in the United States or the District of Columbia. Just as important, a candidate must exhibit the special qualities of

leadership, commitment and professionalism that characterize JAGC service.

Qualified and motivated lawyers who can meet these demanding requirements will find that they can make a mark in the Army, and also advance their professional careers.
The broad scope of the Army's mission provides many opportunities for professional challenge and development. This, coupled with the sense of pride derived from working with a select group offawyers in a "law firm" rich in tradition, makes for a well-rounded and confident lawyer. Whether you stay three years or thirty, service in the JAG Corps will develop and enhance your professional skills to the utmost.

THE CASE FOR EXCELLENCE

The JAG Corps demands excellence. An officer in the Corps must maintain the highest personal and professional standards. A JAGC officer must be a capable officer as well as a first-rate attorney.
In striving for excellence, the Army requires that only the best minds are accepted in the JAG Corps. Excellence also creates a stimulating environment where a bright, legal mind can thrive.

You will be involved in providing services in a broad spectrum of legal disciplines: assisting soldiers with legal problems; representing the Army in contract matters; participating in civil litigation and claim settlements; and trying criminal cases at courts-martial.

As part of the JAG Corps, you will have a visible place in the American bar not only on a national level, but locally, as well.

The JAG Corps consists of three components. The full-time active duty Army, the Army National Guard, and the United States Army Reserve where officers serve part-time either in Reserve units or as individuals assigned to active Army units. Each program has its advantages. Regardless of which program you choose to enter, the responsibilities are considerable. But then, so are the rewards.

THE CASE FOR DIVERSIFICATION

As a member of the JAG Corps, you will have the opportunity to develop a working proficiency in diverse branches of the law. JAGC officers stationed throughout the U.S. and in eleven other countries are involved in a broad range of cases.

Upon entering the Corps, you will be given substantial immediate responsibilities and stimulating challenges. But you won't be alone. More

experienced JAGC officers are available to provide advice and assistance when needed. This invaluable experience will give you the kind of skills that would take many years of civilian practice to achieve.

New judge advocates can look forward to gaining experience in the following areas:

Criminal Law. You may be called upon to prosecute or you might be assigned to the Trial Defense Service, giving you the opportunity to appear as a defense counsel in courts-martial. You may serve as an appellate counsel, filing petitions for new trials or other relief and arguing cases before appellate courts, to include the US. Supreme Court. Selected senior officers serve as judges at both trial and appellate levels. You may be appointed a special assistant United States attorney to prosecute federal crimes in U.S. District Court and Magistrate Court.

Legal Assistance. Army attorneys see and counsel soldiers, retirees and their families regarding their personal legal problems. These cases cover many areas such as estate planning, immigration and naturalization law, family law, landlord-tenant law, state and federal tax matters and consumer protection. Legal Assistance attorneys serving overseas acquire hands-on experience in the laws of the host-nation.

Tort Claims. During an average year, JAGC attorneys represent the interests of the United States in a full range of tort claims totaling over 80 million dollars. In addition, over 20 million dollars is recovered from tort feasors involving injuries to Army personnel and property.

Administrative Law. just as corporate supervisors and chief executive officers depend on corporate lawyers for advice in civilian practice, you will be expected to give advice to commanders and staff officers. You can expect to work on issues as varied as personnel law, environmental law, and Privacy Act and Freedom of Information matters, as well as in such areas as intelligence oversight and military enforcement of civil laws.

Labor Law. As the largest employer of civilians in the country, the Army is involved in a considerable amount of labor litigation. JAGC attorneys advise on all aspects of labor management relations for both private- and public-sector union matters. You may be called upon to represent the Army in Federal Court or in administrative hearings before the Merit Systems Protection Board and the Federal Labor Relations Authority.

International Law. Army personnel are stationed in more than eleven foreign nations around the world. It is inevitable, therefore, that questions will arise about the interpretation of international agreements as well as foreign laws. Judge advocates participate actively in negotiating and drafting international agreements such as base rights, status of forces and personnel exchange agreements. JAGC officers observe and report upon foreign trials of U.S. personnel, and assist personnel confined in foreign prisons. They review military operations plans and provide advice on the

laws of war, rules of engagement, domestic law relating to employment of forces and support of our allies, and the legal aspects of civil affairs.

Teaching. Experienced and qualified attorneys may be selected to teach on the faculty of The Judge Advocate General's School at Charlottesville, Virginia; The United States Military Academy at West Point; or other military schools throughout the United States. Besides teaching, the Army will encourage you to publish scholarly articles in the Military Law Review, The Army Lawyer and civilian legal publications.

Medical Law. A few judge advocates specialize in the legal problems peculiar to hospital administration, medical practice and research. They may be involved in such matters as the credentialing of health care professionals, human subject research, risk management programs and medical malpractice claims.

Contract Law. JAGC contract attorneys review most contracts for supplies, services, construction, and research and development; render legal opinions on procurement procedures, bid protests, contract terminations and contract appeal disputes; and serve as legal advisors to contracting officers and boards of award. Judge advocates litigate contract disputes before the Armed Services Board of Contract Appeals and the U.S. Court of Claims.

Civil Litigation. In all cases affecting the Army, judge advocates investigate and prepare the case for trial through preparation of pleadings, motions, and briefs to be used by the trial or appellate attorney JAGC officers frequently argue cases before U.S. district courts and circuit courts of appeal.

THE CASE FOR FURTHERING YOUR EDUCATION

The Army strongly believes in the power of education. Better educated officers make better officers, just as better educated lawyers make better lawyers.

Furthering your education is essential to your professional growth. And nowhere is this stressed more than in the Judge Advocate General's Corps. The Army's JAGC can offer you numerous educational opportunities.

Your education begins as soon as you enter the Corps. As a new officer, you will attend a 2-week military orientation course at Fort Lee, Virginia. Upon completion, you will go on to the Judge Advocate General's School in Charlottesville, Virginia, for a 10-week course in military practice. Reserve and National Guard officers may elect to take the 10-week course by correspondence.

But your education will not end there. Career officers return to the JAG School for the graduate course.

The Army JAG School has earned the respect and admiration of legal educators and scholars around the country. Following approval of the American Bar

Association, Congress statutorily authorized the JAG School to confer a Master of Laws (LL.M.) in military law. The JAG School is the nation's only government agency to award the Master of Laws degree. The combined experience of the staff and faculty is impressive, and their skills represent the best the Army has to offer.

The JAG School also offers numerous short courses which have been approved for credit in most states having mandatory Continuing Legal Education (CLE) requirements.

Career officers who show exceptional qualities have an additional opportunity to continue their education. By studying at various civilian universities at government expense, those officers selected obtain an LL.M. in certain specialized areas of the law. These selections are based on the officer's demonstrated abilities as well as the needs of the Army.

Some career officers are also selected to attend advanced service schools such as the Command and General Staff College, the Armed Forces Staff College, the Army War College, the Industrial College of the Armed Forces and the National War College.

THE CASE FOR AN OFFICERS WAY OF LIFE

There are many intangible rewards in becoming an officer in the U.S. Army. a chance to develop leadership skills, a sense of pride in your uniform and the knowledge that you are serving your country.

As an officer in the U.S. Army, you are a professional. You will enjoy the respect and privileges that come with rank, including access to one of the Army's oldest institutions, the Officer's Club. Here you will find a relaxed atmosphere for informal socializing, recreation and dining out.

The Army wants sound bodies as well as sound minds. Almost every post has facilities for golf, tennis, swimming, bowling and other sports.

On almost every post you (and your family) will be eligible to live in government living quarters. In the event that military housing is not available, you will receive a nontaxable quarters allowance to help defray the cost of civilian housing. In addition, cost-effective goods and services are available at commissaries and post exchanges.

Elementary schooling is provided for children on or near every Army installation. In the United States, high school children usually attend civilian high schools. And overseas, education is provided for children of Army personnel.

The Army has an extensive medical care program available. This includes routine medical care and hospitalization for family members, and free dental care for service members. Dental care is also offered, as available, for families stationed outside the U.S. and at select posts in the U.S.
You can broaden your horizons in the Army. The JAG Corps has offices in Europe, the Far East and Panama. Officers and their families serving overseas become greatly involved with their host country learning language and local customs. And each year an officer earns 30 days paid vacation, allowing time for exploration and travel.

The Army also considers your future, and offers a liberal, retirement program which, under current law, entitles officers to retire with as little as 20 years of service. Retired officers also retain lifetime medical coverage, commissary and post exchange privileges, officers' club use and all the other benefits they enjoyed as officers in the U.S. Army.
{Emphasis added}

THE CASE FOR THE NATIONAL GUARD AND THE ARMY RESERVE

Approximately two thirds of Army judge advocates serve in the United States Army Reserve or in one of the fifty-four National Guards (fifty states, District of Columbia, Puerto Rico, Virgin Islands and Guam).
Guard and Reserve judge advocates come from backgrounds ranging from prior active duty judge advocate service to direct commission with no prior military experience. All must maintain the highest standards, ethical and academic, and be physically fit.

Serving in the Guard or Reserve offers the unique opportunity to have both a military career and your chosen civilian occupation. Balancing the demands of each can at times be difficult. The Guard or Reserve programs offer options that can assist you. A judge advocate officer may apply for transfer from one option to another.

Troop Program Units (TPU). Both the United States Army Reserve and the National Guard have Troop Program Units. Judge Advocates in a TPU serve with their active duty counterparts.

A typical year serving in a TPU includes training one weekend a month at a Reserve center or Guard armory and fifteen consecutive days at a military installation. You receive pay and are credited with points towards qualifying for military reserve retirement benefits at each training assembly.

For military career planning purposes, serving in a TPU unit fulfills the goal of obtaining the minimum 50 retirement points required annually for a

quailfying year for retirement benefits.

Individual Mobilization Augmentee (IMA) program. A second option in the United States Army Reserve is the Individual Mobilization Augmentee (IMA) program. An IMA officer trains at his or her assigned duty station 12 days for pay and retirement points each year. IMA judge advocates are individually assigned to Active Army or other government offices for their annual training.

During the remainder of the year the IMA officer must earn an additional 22 retirement points to have a quailfying year for retirement purposes. These points can be earned by completing various Army correspondence courses or doing individual legal tasks which they assign. This option gives the reservists greater flexibility in adjusting military duties with his or her civilian calendar.

Individual Ready Reserve (IRR). Members of the IRR have no mandatory annual requirements, but many continue progressing in their military career. This option is not available to new appointees on their initial tour. It is available, however, after an initial tour if other obligations temporarily preclude participation in a TPU or IMA position.

A Total Force. The Judge Advocate General's Corps is a Total Force. When mobilized there is no distinction between Active, Reserve or National Guard Judge Advocates. We are a team dedicated to perform the judge advocate missions.

THE WAYS TO A COMMISSION

Direct appointment from civilian life. Qualified individuals may be commissioned directly from civilian life, without any prior military experience. Application may be made as early as the fall semester of the last year of law school. Graduation and admission to practice before the highest court of a state or a federal court are necessary before a commission may be granted, but are not required for application.

Transfer from another branch. Active duty military personnel and Reservists not on active duty may apply for transfer to, and commissioning in, the JAG Corps. They must, of course, meet all requirements for a JAGC commission, including admission to the bar. Law students in the Reserve components may apply for a direct appointment in their last year of law school, noting their Reserve status on the application.

ROTC graduates. ROTC graduates must apply for an educational delay for the purpose of attending law school. ROTC officers on educational delay must

apply for an appointment in the Judge Advocate General's Corps during the third year of law school.

Summer Intern. The JAG Corps hires up to 100 law students each summer to work as legal interns in Army legal offices in Washington, D.C., throughout the rest of the United States, Puerto Rico, Europe and Korea. Interns are hired as temporary civil service employees for a maximum period of 90 days starting in May or June of each year. No military obligation is incurred by participating in the program.

REOUIREMENTS AND SELECTION

To be awarded a commission in the Judge Advocate General's Corps, an applicant must meet all the usual qualifications for an Army commission. These include standards for mental and physical fitness, moral character, security clearance and citizenship. In addition, an applicant must have graduated from an American Bar Association-approved law school and must have been admitted to the bar of either a federal court or the highest court of any state in the United States or the District of Columbia. An applicant must be 34 years of age or younger at the time he or she is commissioned in the Corps. Law school students may submit an application in the fall of their final year of law school. ROTC officers, on educational delay for law school, must submit applications prior to November of their final year of law school.

Each application is submitted to a board of officers in the Office of The judge Advocate General for consideration. The criteria for selection include scholastic record, character, extracurricular activities, leadership ability, and both legal and nonlegal work experience. Each applicant must be interviewed by an active duty JAGC officer who has been designated as a field screening officer. The best qualified applicants are selected to fill projected vacancies.

A three-year tour of duty is required of all applicants who are selected for and accept a direct commission in the Corps. Officers may apply to a career force selection board to remain on active duty in the Corps more than three years.

JAGC representatives visit most American Bar Association-accredited law schools in the fall and spring of each year. Further information may be obtained by writing:

Army JAGC Recruiting and Placement Office
Fort Belvoir, Virginia 22060-5223

Or call toll-free 1-800-336-3315.
(In Virginia, call 703-806-6230 collect.)
The Army National Guard and the United States Army Reserve programs each offer the advantage of military legal Practice to those attorneys aspiring to a law career in the private sector. For more information about the JAGC Reserve Component Program, call toll free 1-800-552-3978.

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Fort Belvoir, Virginia 22060-5223

CALL: Toll-Free 1-800-336-3315 (In Virginia, call collect 703-806-6230)
FAX: 703-806-5382
Note: Information on the web page is subject to change. Contact the Army JAGC Recruiting and Placement Office for the latest information.

Mr. MICA. Thank you for your testimony, your analysis of the situation, and personal experience.

Now I'd like to recognize Mr. Hal Franck, Retirement Activities Office for the Mountain Home Air Force Base.

I recognize you, sir.

Mr. FRANCK. Mr. Chairman, and ranking minority leader, Representatives and staff, I appreciate your invitation to be here today to testify on this very important matter of lifetime sustained health care for our military retiree community and those on active duty with the Armed Services and their families, who are looking forward to an earned retirement.

In addition to heading up the Retiree Affairs Office, I'm chairman of an all volunteer committee of career military retirees with private organization status incorporated in the State of Idaho. One of the major objectives of the committee is to monitor health care benefits earned by the military retiree community through career service spanning three wars and countless expeditionary war cautionary services worldwide.

Our catchment area includes much of rural America with portions of northern Nevada, southern Idaho, eastern Oregon, western Wyoming, with beneficiaries numbering in excess of 25,500, which includes family members and annuitants.

With the advent of Department of Defense Health Affairs privatized TRICARE, many of our career World War II, Korea and Vietnam veterans at age 65 were denied equal opportunity medical appointments at military treatment facilities. Appointments were plentiful prior to TRICARE implementation last year.

The worst aspect of DOD's TRICARE is that retirees, upon attaining age 65, are discriminated against by being unceremoniously dumped from DOD Health Affairs. They are required to re-establish other health care sources with Medicare. Not surprisingly, in rural America, health care providers are not accepting new patients who have been dumped from DOD Health Affairs as high risk beneficiaries.

Medicare does not offer any pharmacy medication maintenance services, forcing the military retiree community to purchase these at full market costs. DOD's TRICARE was designed to shift military health care to Health Maintenance Organizations [HMOs] and Primary Care Managers [PCMs]. Unfortunately, these programs are not working in urban and rural America, because PCMs, who are care givers, are not prepared to accept, nor are they willing to, nor do they now want to participate in either TRICARE or Medicare for that matter.

The country's promise to provide a lifetime of free medical and dental care was made by me as a recruiting officer for the Army and the Air Force while I was on active duty at the onset of the Korean war in Los Angeles, later in Portland, OR. My assignments at the grass roots level was to sell careers to candidates for military service with a promise of free health and dental care in return for a career of service to our country.

I never once had any misgivings or fears that our country would not back me up 100 percent at any time, or with anything less. This Nation and our retiree veteran community are about to move to the 21st century. We must do so with a fresh economic outlook

on health care for our aging beneficiaries. We need to know that in 1972 the military retired community was rated at 7 percent of the active military force. Now, with the advent of the military base closures and drawdowns, those who were eligible to retire were transferred to the retired reserve on retainer pay and becoming available for recall in the event of a national emergency.

Much of our funding saved in personnel drawdowns were budgeted for retired pay, and, not surprisingly, the retiree community burgeoned and became 118 percent of the active military force with very little savings. I must re-emphasize that observation, the retiree community was just 7 percent in 1972 of the active force. But today that percentage has increased to 118 percent of the active force. Basically what has happened here is the savings on personnel were transferred from active duty to retiree.

There are ways to help our military retirees. First, we must recognize that Health Affairs by Department of Defense should be limited strictly to their mission: providing healthy warriors to fight the wars when and if necessary and called upon. Second, we must provide access to the Federal Employees Health Benefits Program in rural America to all military retired veterans and their families who are too far removed from veteran or military health care facilities.

Pennsylvania, as I recall, with other States, does not have any military treatment facilities at all. And Federal Employees Health Benefits Program is a proven system. Every Federal employee, with the exception of military retirees and families who are over 65, has access to this program, because it is a proven health care medium. Every hamlet or town in rural America who has a provider, accept Federal Employees Health Benefits Program with not one ounce of disfavor or question, unlike TRICARE.

Finally, to coincide with the next drawdown nationwide it is recommended that all large military hospitals and research facilities be transferred intact and converted to veteran hospital facilities and made available to all military career retired veterans and their families, regardless of age or means test.

The rationale of this, please bear in mind, is that health care at military treatment facilities is designed and staffed to accomplish the mission of fighting wars. On the other hand, veteran hospital facilities are designed, and their mission is to provide health care to veterans regardless of their age or gender, and are people oriented.

Medicare will become the primary payer, making Federal Employees Health Benefits Program a wraparound and a second payer to Medicare. This will create comprehensive coverage, including a complete pharmacy benefit. The argument that military retirees would not be able to pay for the Federal Employees Health Benefits Program option is certainly incorrect, because these retirees are already enrolled and paying for Medigap policies and Medicare supplements. Choice of different health care options is the benefit that Federal employees receive, which military retirees should receive as an entitled benefit for serving their country in winning the cold war.

Caregivers who are not signed on to TRICARE will sometimes mistakenly inform potential beneficiaries that they accept

TRICARE, only to find out later the caregiver is not signed on to TRICARE, but accepts payment for the first portion of care, and the rest must come from the beneficiary, a very unwelcome situation to this family's budget.

A recent Mountain Home Air Force Base TRICARE forum last week for active duty retirees and dependents was to enable beneficiaries to get answers to hard asked questions. Retirees and dependents focused on the issues of billing and reimbursement claims. One audience member stated that TRICARE has a balance limit, and what that plan allows for payment is much lower than my other insurance company. My insurance company is billed first. But when the balance is sent on to TRICARE, I am told that the reimbursements that have been made are more than TRICARE allows. Due to these differences, beneficiaries truly believe that there are double standards taking place on billing with no immediate solutions now or in the future.

As Congress looks to address these concerns, they must understand that there is a growing number of retirees over 65, the current 1.2 million Medicare retirees over 65 that are cutoff from military health care need solutions now. Even with full implementation of Medicare subvention nationwide would meet the needs of 33 percent of this population, because this program can only work near military treatment facilities. The only other alternative that is proven effective and creates choice is the Federal Employees Health Benefits Program.

With lack of space available in military treatment facilities due to DOD downsizing, and the problems affiliated with the TRICARE/CHAMPUS network meeting the demands of its beneficiaries, the time has come for a change in military health care. The Federal Employees Health Benefits Program meets the needs and provides the access for health care options for military retirees who have honorably served this country with the military career.

I thank you.

[The prepared statement of Mr. Franck follows:]

TESTIMONY
OF
HAL FRANCK, MSgt, USAF, Ret.
DIRECTOR
RETIREE AFFAIRS OFFICE, Mountain Home AFB, ID
on
April 28, 1998
2:30 PM, 2154 Rayburn HOB

The House Committee on Governmental Reform & Oversight's Sub committee on Civil Service

SUBJECT: FEHB Program as a complement to military health care

TEXT: Mr. Chairman, Ranking Minority Leader, Representatives and Staff. I appreciate your invitation to be here today to testify on this very important mater of lifetime sustained healthcare for our military retiree community, those on active duty with the armed services and their families, who are looking forward to an earned retirement.

In addition to heading up the Retiree Affairs Office (RAO), I am Chairman of an all volunteer committee of career military retirees with private organization status incorporated in the state of Idaho. One of the major objectives of our Committee is to monitor healthcare benefits earned by the military retiree community through career service spanning three wars and countless expeditionary war cautionary services world wide.

Our catchment area includes much of Rural America with portions of Northern Nevada, Southern Idaho, Eastern Oregon and Western Wyoming with beneficiaries numbering in excess of 25,500 which includes family members and annuitants.

With the advent of Department of Defense (DoD) Health Affairs privatized TRICARE, in April 1997, many of our career World War II, Korea and Vietnam veterans at age 65 were denied equal opportunity medical appointments at military treatment facilities (MTF's). Appointments were plentiful prior to TRICARE's implementation.

The worst aspect of DoD's TRICARE is that retirees, upon attaining age 65, are discriminated against by being unceremoniously dumped from the DoD Health Affairs System and required to re-establish other healthcare sources with Medicare. Not surprisingly, in rural America, healthcare providers are not accepting new patients who have been dumped from DoD Health Affairs as high risk beneficiaries. Medicare does not offer any pharmacy medication maintenance services, forcing the military retiree community to purchase these at full market costs.

DoD's TRICARE was designed to shift military healthcare to Health Maintenance Organizations (HMO's) and Primary Care Managers (PCM's). Unfortunately these programs are not working in urban and Rural America, because PCM's (caregivers) are not prepared to accept, nor are they willing to, nor do they now want to participate in either TRICARE, or MEDICARE for that matter!

The country's promise to provide a lifetime of free health and dental care was made by me as a recruiting officer for the Army and the Air Force while I was on active duty at the onset of the Korean War in Los Angeles and later in Portland, Oregon. My assignments at the grass roots level was to sell careers to candidates for military service with the promise of free health and dental care in return for a career of service to our country. I never once had any misgivings or fears that our country would not back me up 100% at any time or with anything less!

This nation and our retirees/veteran community are about to move to the 21st century. We must do so with a fresh and economic outlook on healthcare for our aging beneficiaries.

We need to know that in 1972 the military retired community was rated at 7% of the active military force; in 1997, with the advent of military base closures and drawdowns, those who were eligible to retire were transferred to the retired reserve at retainer retired pay and became available for recall in the event of a national emergency. Much of the funding saved in personnel drawdown were budgeted for retired pay and then surprisingly the retiree community burgeoned and became 118% of the active military force with little savings. I must reemphasize in 1972 the retiree community was just 7% of the active force, but today that percentage has increased to 118% of the active duty community.

But there are ways to help military retirees:

First, we must recognize that health affairs by Department of Defense (DoD) should be limited strictly to their mission of providing health warriors to fight the wars when and if necessary and called upon.

Secondly, WE MUST provide access to the Federal Employee Health Benefit Program (FEHBP) in rural America to all military retired veterans and their families who are far too removed from veteran or military healthcare facilities. Pennsylvania, as I recall with other states, does not have any military treatment facilities at all. FEHBP is a proven system, every federal employee (with the exception of military retirees and families who are over 65) has access to this program because it is a proven healthcare medium. Every hamlet or town in rural America who has a provider accepts FEHBP with not one ounce of disfavor or question, unlike TRICARE.

Finally, to coincide with the next drawdown nationwide it is recommended that all large military hospitals and research facilities be transferred intact and converted to

Veterans Hospital facilities and made available to all military career retired veterans and their families regardless of age or means test. The rationale, please bear in mind is that healthcare at military treatment facilities are designed and staffed to accomplish the mission of fighting wars. On the other hand, Veteran Hospital facilities are designed and their mission is to provide healthcare to veterans regardless of their age or gender and are people-oriented.

Medicare will become the primary payer, making FEHBP a wrap around and a second payer to Medicare. This will create comprehensive coverage, including a complete pharmacy benefit. The argument that military retirees would not be able to pay for the FEHBP option is incorrect, because these retirees are already paying for Medigap policies, and Medicare supplements. Choice to different healthcare options is the benefit that Federal Employees receive, which military retirees should receive as an entitled benefit for serving their country in winning the cold war.

TRICARE privatization at military treatment facilities is not working as well as it should with drawdowns and DoD budget cuts. Many clinics and services have been either hampered by lack of medical personnel or are being referred to civilian hospitals and clinics; proposed TRICARE-65 legislation will not work in rural America, because military treatment facilities are too far removed from beneficiaries domicile and again caregivers will not sign onto the program because rates paid are less than their costs

Beneficiaries in all cases are required to obtain written referrals form TRICARE prior to attempting to make appointments with clinics, providers and others without referral; many beneficiaries who make that mistake are liable for all care not authorized by TRICARE referrals at MTF's.

Caregivers who are not signed on to TRICARE, will sometimes mistakenly inform potential beneficiaries that, "they accept TRICARE," only to find out later the caregiver is not signed on to TRICARE, but accepts payment for the first portion of care and the rest must come from the beneficiary.

TRICARE Standard (CHAMPUS) has experienced problems in signing on providers into the network, as well as a host of other problems. The low Champus Maximum Allowable Charge , CMAC, rates and slow claims processing discourages physicians to want to participate in the TRICARE programs Finally, the lack of specialists in the network has created distress to beneficiaries enrolled in TRICARE Standard (CHAMPUS).

The need to maintain the current providers , as well as bringing on new ones has been an area of concern in TRICARE prime. The low reimbursement rates negotiated by TRICARE contractors, has limited the number of providers participating in the healthcare program network in my area.

A recent TRICARE forum for active duty and retirees enabled the beneficiaries to get answers for the hard asked questions. Retirees and dependents are focused on the issues of billing and reimbursement claims. One audience member stated, "TRICARE has a 'balance limit' and what that plan allows for payment is much lower than my other insurance company. My insurance company is billed first, but when the balance is sent on to TRICARE, I am told that the reimbursements that have been made are more than TRICARE allows." Due to these inefficiencies, beneficiaries truly believe that taking care of billing problems is a continual problem with no solutions in the future.

As Congress looks to address these concerns, they must understand that there is a growing number of retirees over 65. The current 1.2 million Medicare Retirees over 65 that are cut off from military healthcare need solutions now. Even with full implementation of Medicare Subvention nationwide would meet the needs of 33% of this population, because this program can only work near a Military Treatment Facility (MTF). The only other alternative that is proven effective and creates choice is FEHBP.

With lack of space availability in (MTFs) due to DOD downsizing and problems affiliated with the TRICARE/CHAMPUS network meeting the demands of its beneficiaries, the time has come for a change in military healthcare. FEHBP meets the needs and provides the access to healthcare options for military retirees that have honorably served this country in their career.

Mr. MICA. Thank you, and thanks to all of our witnesses for their testimony this afternoon. I have a comment from the written statement of Acting Assistant Secretary Gary Christopherson, who is going to testify shortly. In his written statement, he said, let me quote, "Active duty members, their family members and retirees, their family members and survivors who are under age 65 have excellent affordable managed care and fee-for-service health plans from which to choose."

Do you agree with his statement, Mr. Franck?

Mr. FRANCK. I don't think I quite understood the complete question, Mr. Chairman.

Mr. MICA. This is what the Acting Assistant Secretary has said. He said, "Active duty members, their family members and retirees, their family members and survivors who are under age 65 have excellent affordable managed care and fee-for-service health plans from which to choose."

Mr. FRANCK. Well, I would certainly question the statement somewhat, because TRICARE, though it started out to work as a health maintenance organization, it may do well around populated centers and around military treatment facilities. But in rural America, and I would describe that everything west of the 100th meridian certainly could be considered as rural America, because there are not a lot of providers there that are willing to sign on to the program. As a matter of fact, some of them are now signing on, and they are not accepting new patients.

Mr. MICA. Mr. Simmons, again a quote, "Active duty members, their family members and retirees, their family members and survivors who are under age 65 have excellent affordable managed care and fee-for-service health plans from which to choose."

Mr. SIMMONS. The only fee-for-service that I can think of that he may be referring to would be TRICARE. And if he would—I would bet he's in FEHBP. And I would bet that if he went out and talked to some physicians, and these guys have to make a living, and he had to put up with what they put up with in trying to get paid, all you have to do is get up and look on the TRICARE form. It's——

Mr. MICA. Maybe I've got the solution. Maybe we could put some of our ranking military and Department of Defense people in TRICARE, and I'm talking about political appointees and others, and Members of Congress and try that out on them.

Mr. SIMMONS. In that case, sir, I believe Congress would put FEHBP through within the next week.

Mr. MICA. Dr. Glacel. Again, this quote, "Active duty members, their family members and retirees, family members and their survivors who are under age 65 have excellent affordable managed care and fee-for-service health plans from which to choose."

How does that strike you? You look like you're under 65.

Ms. GLACEL. I am, but I have to ask you a favor first. If you do this demonstration project where you put senior folks, Members of Congress, political appointees and military in TRICARE, for those who have already been there, can we opt out?

My husband is one of those senior people, and he would not wish to go through this again. I think where I would take exception to that quote is the term "excellent," and I would question how that's

defined. Once I get through the gatekeepers, I do have excellent care. I like the doctors and the physical therapists and the specialists that I deal with.

I think once I get through the gatekeepers, I get excellent care. I do have a choice, I can choose prime, extra or standard. But the choice is so limited among those that access is so difficult with the rules that are just a bureaucratic hassle with the administrators who don't really understand how to make a seamless medical system work.

They don't understand how to take the military treatment facility and the civilian providers and make them mesh into a seamless medical treatment for the beneficiaries. And it is the bureaucracy that is the problem. There is excellent care if you work for the bureaucracy. The choices are not broad enough.

Mr. MICA. Ms. Hickey, what's your response to this?

Ms. HICKEY. It's not true, except perhaps on a piece of paper. Choice is not available to those who do not live around military treatment facilities; whether they're active family members or whether they're retirees. They're stuck with the fee-for-service, more or less, with its high copayments. You don't have a choice, even if you live near a military hospital, because if you choose the, quote, fee-for-service program and then you need nonemergency inpatient care and your body has something they need to practice on, they're going to haul you back into the military hospital with something called the nonavailability statement.

Now, to the best of my knowledge, there's nothing in a Federal Employees Health Benefits Program that is a fee-for-service program or indemnity program that can force you into another system when you get sick.

Mr. MICA. I think the one difference between my bill and some of the other items that have been proposed is that it does allow coverage for dependents of active duty personnel.

Would you all agree with that as far as any necessary inclusion if we would pass some demo project or at least initially get into this? Mr. Franck.

Mr. FRANCK. Well, you're speaking of the active duty dependents. Is that what you're speaking of?

Mr. MICA. Right. And some of the other cases we heard today would, I guess, not be addressed unless we get that.

Mr. FRANCK. Being closely involved at the Mountain Home Air Force Base Hospital, you hear from time to time catastrophic things. You hear, from time to time, things that can't be identified. I couldn't really testify that these are true or they're not true. And I would hesitate to comment on what I observed.

Mr. MICA. Mr. Simmons and Dr. Glacel, I think you both concur on the need for any pilot project or demonstration project or any approach we take, the need for including dependents?

Mr. SIMMONS. Absolutely. I don't see any need for any change at all in FEHBP. We don't need a Rube Goldberg version of what everyone else has. If those 9 million people who are currently in FEHBP are not an adequate representation of what would happen if the 8 million military were to go into the program, somebody needs to explain to me why. I don't think we're that much different from those folks.

Mr. MICA. Dr. Glacel?

Ms. GLACEL. I would certainly support having military family members be part of any demonstration project.

Mr. MICA. Ms. Hickey?

Ms. HICKEY. Absolutely. Not only that, I think the Department of Defense ought to jump at the opportunity. It's the one way of providing for our families in remote areas, our recruiting families, our ROTC families a decent health care benefit. They have been trying to do TRICARE prime remote which gives the families all the strictures of an HMO and none of the benefits once they go beyond the primary level. It seems to me if they were interested in their care, they would be jumping at an opportunity to do that.

Mr. MICA. Some individuals have said we haven't given TRICARE enough time to work.

How do you respond to that, Mr. Franck?

Mr. FRANCK. Well, again, I see that there is a problem with TRICARE, and that has to do with age eligibility. For example, my spouse is 14 years my junior, and she's eligible for TRICARE and we paid in $230 dollars a year and——

Mr. MICA. My question really is, we've had a few years experience with TRICARE and everybody says: "give it a chance. There are just a few glitches in it; we'll work it out or we'll figure out how to get coverage where there isn't coverage." Do you think that's going to solve the problem from your analysis or from what you've seen?

Mr. FRANCK. I don't really think it's going to solve the problem. Again, I would like to comment on why my spouse is eligible for TRICARE and I'm not because I'm over age 65. Of course, she didn't serve overseas like I did and so, therefore, I think it's an unfair way to treat the military retiree community over age 65.

Mr. MICA. Ms. Hickey, do you think we should wait this thing out and work on the rough edges?

Ms. HICKEY. Mr. Chairman, I have to go back to the fact that TRICARE was designed to be part of a bigger program. I'm not going to debate the merits of the bigger program, but we didn't get the bigger program, and it's a spoke without the wheel. How can it possibly ever work? In the meantime, 3,000 World War II retirees are dying every month while they wait for care.

Mr. MICA. Mr. Simmons, you have done some interesting math, and you seem to feel that TRICARE may be costing money as supposed to giving this option. Do you feel pretty confident about the statistics of the math you've run on this?

Mr. SIMMONS. Absolutely. I pulled those off of Government web sites. TRICARE is Medicare in its infancy stage. If you look at the reasons why FEHBP works, you'll have your reason for why TRICARE will not work. If it were a business and it were my business, I'd cutoff my losses in a hurry.

Mr. MICA. Dr. Glacel, you said your husband was pretty well-positioned, I don't recall, what was his rank or position?

Ms. GLACEL. He's a brigadier general.

Mr. MICA. Brigadier general. And even so, with his standing and your educational background, you still have one hell of a fight to——

Ms. GLACEL. That's absolutely correct. And in answer to your question about TRICARE being in its infancy, I would say that I have been told that Region 6, where we live, is touted as the best and the longest running region for TRICARE. Even so, it has not worked out the kinks. In fact, I think the kinks are getting worse. I'm not willing to risk lives of retirees or active duty or family members while TRICARE works out its kinks.

Mr. MICA. And your scenario here, I don't think—it doesn't detail your entire experience in detail. I think you must have gone back and provided just sort of a cursory review of the beginning of your—you keep very detailed——

Ms. GLACEL. Right. When I started having difficulty with TRICARE, I started keeping dates and names on a calendar. In February, I met with a DOD official, and he encouraged me to write it all down. I had really resisted writing it all down, because I knew how long it would take me to do that.

Mr. MICA. I'm glad I put it in the record. It is a little bit longer than anything I think we put in to date. But it provides the documentation and detail for the first time showing how an individual struggled with the system and that even if you can get to the care, the hassle and survival of just getting access, and achieving anything from a system that is not compassionate.

User friendly?

Ms. GLACEL. No, it is not user friendly. I had less difficulty working through the medical system in a foreign language than I have had working through the medical system with TRICARE.

Mr. MICA. It's unbelievable. We also heard Mr. Simmons' experience, so hopefully we can find something that will take its place, and we can convince those in authority that this is long overdue.

I had one more question for Dr. Glacel. There's a case involving Toni McLeod, and I've had an opportunity to read your March 9, 1998, letter to a Dr. Sue Bailey. In that letter, you discuss the tragic experience of Toni McLeod, the wife of a staff sergeant under your husband's command, when she was stricken also with breast cancer.

Could you tell us just briefly what happened to Mrs. McLeod?

Ms. GLACEL. Yes. I would ask you to understand that I don't have quite the detail on dates and specifics that I did in my own testimony, so although I'm under oath, I will give you approximate information on Toni's case. Toni is a 32-year-old wife of an E–6 who was assigned to Korea, and last May, just a year ago, Toni discovered her own lump in her breast. She made a same day appointment. She was registered for TRICARE prime, and got in to see a doctor on the same day, without a problem. The doctor ordered an immediate mammogram.

She was encouraged to walk her paperwork through, so that there would not be a time delay; however, when she reached the radiology clinic, the receptionist in the radiology clinic said to her, well, you're only 32, you have no history of breast cancer, it's probably just a cyst. So despite the fact that the doctor ordered an immediate mammogram, she was scheduled for a breast ultrasound 3 weeks later.

When she went in 3 weeks later for the breast ultrasound the technician exclaimed, oh, my God, that thing's huge, why didn't you

have a mammogram? Toni went back to the same receptionist to get an appointment for a mammogram, which was booked 3 weeks later. By then, it was 6 weeks from the time that she discovered the lump, and she felt it growing. She had the mammogram, and she began calling back to get somebody to give her the results without success.

What we have subsequently learned, because of an investigation about this case going on at Darnall Army Community Hospital, is that when the radiologist read the mammogram and confirmed, yes, it is a tumor, probably cancerous, the records were sent to surgery. The surgeons were short staffed because there were so many surgeons in Bosnia. No one called Toni, they just kind of sat on this thing. How do we get this to civilian care provider?

It had to walk its way among the three buildings that I've already talked about in terms of getting into the TRICARE system for care. And so by the time it walked its way through the—through the three buildings, Toni was beside herself and had opted out. And she had gone on her own to see a civilian. She subsequently had mastectomy, chemotherapy. By the time her husband came home from Korea for all of this on a compassionate reassignment, the tumor had returned and had invaded her chest wall.

She subsequently had her chest wall excised just last month. She finished going to San Antonio for a blood stem cell transplant. She began, today, 6 weeks of radiation treatment, and all of this now is being done with a cross share. This is an E–6 wife with a young child. She had to quit her own job, because of her medical situation. She has child care payments. She has copayments and they've lost her income, and it's tragic.

Mr. MICA. It's especially tragic, when everyone tells you that as soon as you find any indication that you need to seek immediate treatment. Our system obviously is failing, not only you and others we have heard today, but many who are active personnel dependents of retirees that we need to do something about it.

I want to thank each and every one of you for coming today for your testimony, for your participation. We have very broad support in the Congress. It's a question of trying to reach a compromise and finding a way to institute this as soon as possible.

We look forward to working with you both in the association and with the individuals who have taken leadership in this position based on their own experience. Now, we thank you, and we'll dismiss you at this time.

I'd like to call our last panel and our last panel is one individual, our Acting Assistant Secretary of Defense for Health Affairs in the Department of Defense, Gary A. Christopherson.

Mr. Christopherson, we do swear in our witnesses.

[Witness sworn.]

Mr. MICA. Welcome to our panel this morning. We've heard Members of Congress and our last panel of witnesses. And as I indicated to them, you're welcome to submit lengthy testimony for the record if you so desire, and we will recognize you for your statement.

Mr. CHRISTOPHERSON. Thank you, Mr. Chairman, and I will submit my full statement for the record.

Mr. MICA. Without objection, it will be made in its entirety a part of record.

STATEMENT OF GARY A. CHRISTOPHERSON, ACTING ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Mr. CHRISTOPHERSON. Thank you, Mr. Chairman.

Mr. Chairman, thank you for the opportunity to testify here today. Let me go through a few brief remarks here. One is that the military health system in TRICARE is a strong system, and it is getting stronger every day. In terms of caring for you we have over 65 beneficiaries, we have a strong personal commitment to this, like I said, personally and directly, both of my involvement when I spent time on the Hill, actually with your brother on the House Committee on Aging and also as well as my whole support for the TRICARE senior demonstration project, which I personally helped put together in my beginning time with the Health Affairs.

Let me also say that TRICARE and Medicare are the foundation of whatever solution we're going to try and find here. But understand, as well, that Congress and the administration have a resource dilemma, and the great difficulty we'll go through here in a few minutes is how to take care of our over 65 beneficiaries.

There is uncertainty and there is risk in a number of the approaches that we're talking about here. It is incumbent upon all of us working together to exercise due care. It is important to understand, as is indicated by some of the early witnesses and in your remarks as well, that our mission is twofold. One is to protect the health of the troops wherever they may go, whether it's in wartime deployment or any other kind of deployment. Second is to take care of our people wherever they may be; beneficiaries, whether retirees, active duty dependents, whatever.

TRICARE is not perfect, I'll be the first to admit it. I know it well. Barbara Glacel's case is appalling. It is tragic. I personally apologize for it. My staff has apologized for it. We are investigating that case to find out more what it is about and how to make sure we can avoid these problems in the future.

But no system of care, especially one as large as ours, the $15 billion system, or FEHBP, is a perfect system. VA is in the same kind of situation as well. We are all pushing very hard to make sure we provide good care and good access. TRICARE's mistakes are being fixed and lessons are being learned and applied. It is a strong, caring and accountable system. It's a maturing system, getting stronger and charging forward.

We're reforming the military health system in many large ways. We are right designing, right sizing and right costing the system. We are managing with nearly flat funding. We are working very hard with our beneficiaries to improve upon the care. We are delivering accessible, affordable quality and satisfying care. We are managing the performance and health outcomes, making smart decisions and instituting an evidence based prevention program.

But again we have a ways to go. Access, which is one of the issues raised by the beneficiaries here this afternoon, is clearly one of the most difficult tasks we have. I think as well it was laid out,

when beneficiaries get into care, in general the care is very good, I think comparable with any private system.

When you look, for example, we put ourselves through the same standards of care that are done in the private sector with joint commission, independent peer review, again to make sure we have a good system committing to care for our beneficiaries.

Let me talk for a few moments about the caring for our older retirees. It's the main subject for the hearing today. First, let me emphasize that it is a great debt owed to our retirees for the service they gave to this country. We have a sincere and abiding commitment to try and provide care for them. We joined forces and worked very closely to get TRICARE senior and Medicare demonstration project, a major victory after about 10 years of effort on both our parts.

Let me emphasize as well that whatever we're going to be doing is that TRICARE senior is the foundation for it. TRICARE senior, which is Medicare and TRICARE put together, essentially provides a large amount of care for essentially no new government dollars, and again the beneficiary that we have worked to do this demo together, and also to work toward enactment of TRICARE senior nationwide.

But let me go back to a key problem here. In order to understand where we are today and how to proceed forward, we have to understand the issue of the resource. Expanding TRICARE or FEHBP or a number of approaches to over 65 beneficiaries requires new resources. And that's new resources, not in small amounts, we're talking about anywhere from hundreds of millions of dollars to over $1 billion annually, depending upon whose estimates you use.

To date, neither the Congress nor the administration has yet found the dollars it would take to fulfill that commitment. And again the commitment is there, but getting there and getting the dollars is a whole other question.

Now, there are a number of proposals that have been put forward to FEHBP to be used for the military beneficiaries and over 65s. Let me make a couple of key points to understand how that can play out, especially with no new resources. If FEHBP 65 is enacted and the dollars are not available to the Defense health program, we're talking about the beneficiary, including space, aid, care, paying a 28 percent premium, but they do get more choice, we acknowledge that right from the beginning.

TRICARE senior, we're talking to see a loss of TRICARE senior, the Medicare subvention, because we will not be able to maintain our level of effort, MGS, the risk of downsizing and closings, readiness, the loss of over 65 beneficiaries. Reduced military treatment facilities, fewer physicians, creates a great problem for us for readiness. And the Medicare trust fund, a partner with us in the demo, there's an increased cost and a potential for a cost shift from DOD if those are followed through.

If FEHBP under 65 is enacted, we create an even greater set of problems in a slippery slope, eventually dismantling the military treatment system both for readiness and nonreadiness purposes. So the concerns I think we have to keep in mind are, without new funding, we have a problem. Including under 65 beneficiaries cre-

ates an increasing difficulty, allowing FEHBP outside the—inside the catchment area particularly creates difficulties here.

We must protect Medicare subvention. An awful lot of people spend an awful lot of time making sure that was in place and it is happening. And that we're doing any of these kinds of policy decisions without doing demonstrations or tests has a lot of uncertainties and risks in there. That's the great thing you have to watch out for.

In closing, again the system is being strong and getting stronger. It's not perfect. We know that. We know that very well. We are committed to taking care of our people both under and over 65. We are committed to trying to find solutions for over 65 retirees to whom we are indebted and committed to their service. Again, TRICARE and Medicare are key.

Again, we have a resource dilemma that we in the Congress have to try to figure out if we're going to try and move forward. And again I would only counsel for all of us that we exercise due care in how we proceed forward.

Mr. Chairman, I'm available for any questions you may want to ask.

[The prepared statement of Mr. Christopherson follows:]

Statement by
Gary A. Christopherson
Acting Assistant Secretary of Defense for Health Affairs
on FEHBP as a Complement to Military Health Care
Before the Subcommittee on Civil Service,
House Government Reform and Oversight Committee
On April 28, 1998

Mr. Chairman, Distinguished members of the Committee, I appreciate the opportunity to discuss the potential impact of providing access to the Federal Employee Health Benefits Program for military beneficiaries. First, in response to your request, I would like to address the status of TRICARE.

TRICARE has been implemented worldwide over the past three years. There were many reasons, many change factors that brought about the decision to totally transform how we provide care, and how we do business in the Military Health System.

The rapid rise in health care costs and the closure of military bases and their medical facilities required the Department to initiate an intensive reengineering effort to design new ways to provide the military health care benefit. For instance, as a result of Base Realignment and Closure actions, 35 percent of the DoD medical treatment facilities (MTFs) providing services in 1987 closed by the end of 1997. During the same time period, the number of people eligible for care in the MHS decreased by only nine percent. The loss of available services was coincident with a dramatic shift in categories of beneficiaries from active duty members and families to retired members and their families. Moreover, in the 1950s, our retiree beneficiaries made up eight percent of the total population eligible for military health care – today, retirees account for 50 percent. The ever-increasing demand for health care began to exceed our capacity for providing it and precipitated one of the greatest peacetime management challenges ever faced by the Department.

The TRICARE managed health care system was developed as the Department's response to these challenges. It is our military health strategy to utilize the existing military infrastructure to an integrated health care delivery system based on direct care and contractor support. This system provides comprehensive, cost-effective care to active duty members, their families and other eligible beneficiaries in all the Uniformed Services. The TRICARE system offers expanded access to care, a choice of health care options, consistent high quality health care benefits, and reduced health care costs for beneficiaries and taxpayers alike. TRICARE is a managed care program modeled after civilian managed care standards and is managed by the military in partnership with civilian contractors. For each of 11 designated Health Service Regions in the United States, as well as in Europe, the Pacific, and Latin America, a senior military health care officer, called the Lead Agent, is responsible for coordinating the delivery of all health care to eligible beneficiaries who live in that region. Day to day health care decision-

making is done by primary care managers, with oversight by local military medical treatment facility commanders.

This management approach depends upon excellent communication and cooperation among all parties. To this end, we hold an annual national TRICARE conference and yearly local conferences in each region. We also rely extensively on emerging technologies such as video and teleconferencing, E-mail, and the World Wide Web to exchange information, explore issues, and solve problems.

Last year we added a new component to our communications endeavors -- "Partnering." DoD, Service, Lead Agent, and Contractor staff meet face-to-face for several days to discuss issues of mutual concern, to air differences and to come to a new level of understanding regarding mutual interests in making TRICARE succeed. The feedback from these sessions is invaluable as we fine-tune TRICARE to make it more customer-focused and assure that it continues to be the best health care system we can provide for our beneficiaries.

TRICARE Management Activity

The Deputy Secretary of Defense, in his Defense Reform Initiative, directed establishment of the TRICARE Management Activity (TMA) to strengthen oversight and performance of the TRICARE program. The new organization began operating on February 10. Working closely with the Surgeons General, the TMA will monitor system performance through the TRICARE Lead Agents and specific performance metrics associated with quality, health care outcomes and cost. The TMA includes several operational elements of the Office of the Assistant Secretary and two previously existing field activities – Defense Medical Program Activity and TRICARE Support Office. Operating as a unified organization, the TMA will address TRICARE as an integrated health care system, ensuring that the policies of the Assistant Secretary are effectively and uniformly implemented.

Access to Quality Health Care Initiative

Improving the quality of our health care delivery, beneficiary access to that quality care, and communications with our beneficiary populations is a top priority.

A major element of the national agenda is health care quality. The civilian health care system has been undergoing a dramatic transformation over the past several years and the Military Health System has mirrored these changes. Health care quality is one of the most important considerations for our beneficiaries. We have developed a 13-point Access and Quality Improvement Initiative. The military Services have either resolved the issues on the 13 points, or have a plan for resolution.

The 13-point initiative includes --

National Practitioner Data Bank (NPDB) Reporting. We have instituted improvements in our reporting to the NPDB.

- Provider Licenses. We have taken steps to assure that all providers have a full, valid, and unrestricted license in one of the licensing jurisdictions. Providers holding "special" licenses were removed from direct unsupervised clinical practice and are required to obtain a full, valid and unrestricted license.

- Healthcare Consumer Committee. We have established Health Care Consumer Committees at all medical facilities. These committees will pay priority attention to the needs of the enlisted populations.

- Communication with Beneficiaries. Our concern is that beneficiaries should have complete confidence in the MHS, TRICARE and their health facility. One way to do that is to create open communication with our patients. To begin that process, each facility will have a public report card. The report card will include results of our patient satisfaction surveys, performance in meeting required access standards, and Joint Commission on Accreditation of Healthcare Organizations results. Report cards will be discussed at the Health Care Consumer Committee meetings, issued in newsletters and posted on the World Wide Web. This improved communication will aid in early identification of issues important to our beneficiaries.

- Patient Directory (Handbook). Choice is a major marketing item in the civilian health care sector. Information about the training and experience of our providers has not been available to most of our beneficiaries. To continue the open communication and gain our beneficiaries' confidence, each facility will create a patient handbook. These handbooks will identify all providers working at that facility along with their training and experience. This information will offer our beneficiaries a sound basis for making their health care choices.

- Customer Satisfaction. We measure beneficiary satisfaction with the MHS as well as with an individual episode of care. In a further effort to satisfy our beneficiaries, the results of these surveys, by facility, will be included in the Report Cards. Our expectation is that beneficiaries may well see that there is good reason to be proud of their health care system. However, some may also see that outstanding care is not as available as it should be. In these cases, the open dialog, either individually or through the Health Care Consumer Committee, will assist to improve that facility and make the entire system stronger.

- Quality Management Report. Established in the mid-1980's, the annual Quality Management Report tracks quality practices and processes in each of

the military services. This report also serves as a means to share innovative ideas and information. We discontinued the report in 1995, however, in light of the criticisms regarding the quality of the MHS, we have reestablished the report. The first report will be published in the second quarter of 1998.

- Centers of Excellence. We, along with the civilian health care community, realize that better patient outcomes can be obtained when specific procedures or treatments are done frequently. This situation applies particularly to specialty care and usually occurs in medical centers. While a well-trained orthopedic specialist can perform total hip replacement, such a procedure in a small facility without the necessary support and follow-up care could result in a patient outcome less desirable than one in a facility prepared to handle that type of procedure. In an effort to ensure the best patient outcomes, we are establishing Centers of Excellence and Specialized Treatment Service areas. So far, we have approved six centers and have several more requests pending approval. We expect that the overall quality of care delivered in our system will improve with these centers.

- Full TRICARE Implementation. As discussed elsewhere, we are moving to full implementation in TRICARE. TRICARE is our military health plan and this year we expect to have implemented it throughout the U.S. In TRICARE Prime, each enrollee will have a primary care provider, or team of providers, who will offer not only continuity, but also guidance for needed care and assistance in obtaining that care.

- Eliminate the Accession of General Medical Officers. Our review found that the community standard of using general medical officers in front-line, primary care roles has changed. Indeed, medicine has been changing at a very rapid rate with medical knowledge doubling every five to seven years. General medical officers are physicians who have four years of medical school plus one year of post-graduate training. We believe that it is imperative that providers with a higher level of training be assigned to our front-line, primary care positions. We will phase out all new general medical officer accessions over the next three to four years and will require that providers in isolated assignments have a minimum of three years post-graduate training.

- Continuous Evaluation of the Military Health System. As with any large organization, we believe the MHS will benefit from continuous evaluation to find ways to improve its processes. We believe we have the tools to consistently measure and evaluate our progress. These tools coupled with our 13 Access and Quality initiatives will assist the MHS to better meet the expectations of our beneficiaries, and to demonstrate that it is a high quality system of health care delivery.

- Strengthen the National Quality Management Program. In the early 1990's we began to look at aggregate data from clinical records across the MHS and to study the processes which seem to produce the best outcomes of care. The National Quality Management Program looked at six major areas (Obstetrics, Cardiovascular Disease, Orthopedics, Pediatric Asthma, Diabetes, and Mental Health) and evaluated which facilities in our system had the best outcomes. Study reports were made available to every MTF for the staff to examine the processes for those facilities having the best outcomes and to determine where the MTF might improve. This information sharing will result in the improvement of patient care throughout the MHS. The quality management studies continue, with one on mental health due for publication this year. In medicine some variations in practice patterns make little clinical sense. With the DVA, we are working jointly to review areas where standardized clinical practice guidelines make clinical sense. A more standardized approach in some clinical areas will improve health care delivery and result in better patient outcomes.

- Advances in Automation. We believe that rapid and accurate transmission of clinical data is of vital importance to aid our providers in making correct clinical decisions for their patients. We are leveraging advanced technologies and have several automated systems in development. CHCSII, an integrated system linking laboratory, x-ray, pharmacy and other support services to an automated patient record, will be fielded at 3 sites in March 1998. The Computer based Patient Record and Personnel Information Carrier, once operational will significantly improve the flow and availability of patient information. These systems and others will contribute to improved processes within the MHS and result in greater quality of care.

TRICARE Options and Benefits

TRICARE offers beneficiaries three options for their health care. They are TRICARE Standard, a fee-for-service option that is the same as standard CHAMPUS. TRICARE Extra, a preferred provider option which saves money over Standard, and TRICARE Prime, a network of military and civilian hospitals, clinics and health care professionals which is similar to civilian health maintenance organizations (HMOs). Active duty personnel are automatically enrolled in TRICARE Prime but their family members may choose which health care option they prefer. The TRICARE system has several unique features especially designed to help beneficiaries manage their own health care and gain quick and easy access to the system at their appropriate level of need. TRICARE Service Centers are located in each Health Service Region; normally we have one at every MTF or located near by. Qualified health professionals answer questions, make appointments and help beneficiaries decide which health care option is best for them. Health Benefits Advisors assist them with claims paperwork and answer questions about any of the TRICARE programs. Health Care Finders make beneficiaries' referral appointments to physicians and specialists participating in the TRICARE network. For

Medicare-eligible retirees, they locate physicians who accept Medicare payments for treatment when space is not available in a military hospital or clinic. Another feature available in most regions is the Nurse Advisor who is accessible by telephone to provide health care advice and assistance 24 hours a day, 7 days a week.

As a new program, TRICARE continues to evolve and to improve. Efficiencies and improvements originate from many sources, to include our beneficiaries. Two beneficiary suggestions that we have taken action to implement are enrollment portability and elimination of multiple co-payments. With the implementation of TRICARE in most locations worldwide, portability now is possible. For active duty families portability of TRICARE Prime began in July 1997; for retirees, their families and survivors it began in December 1997.

Multiple co-payments for ancillary services associated with a TRICARE Prime office visit was an unintended defect in the Prime benefit. We have a solution to this problem and expect to make the necessary changes in the very near future.

Pharmacy

The pharmacy benefit is the one most in demand by our beneficiaries. Our goal is to ensure the availability of an equitable uniform pharmacy benefit for our eligible beneficiaries regardless of geographic location. In concert with this goal and in light of the numerous BRAC actions, the pharmacy benefit under TRICARE includes provisions intended to prevent the potential loss of the pharmacy benefit to beneficiaries who relied on a Military Treatment Facility (MTF) for obtaining pharmaceuticals. Both a mail order and a retail pharmacy benefit under TRICARE are available to CHAMPUS beneficiaries and to those Medicare eligible beneficiaries who have been adversely affected by a BRAC action.

We implemented a National Mail Order Pharmacy (NMOP) Program in October of last year. This program helps to standardize the pharmacy benefit, offers patients greater convenience and access, and maximizes the use of Best Price Federal Pricing. This pricing ranges from 24 to 55 percent less than the Average Wholesale Price of pharmaceuticals. The NMOP covers active duty personnel worldwide, overseas CHAMPUS eligibles, BRAC Medicare eligibles, and TRICARE Prime enrollees whose Primary Care Manager is in a MTF. In the first two months of operations over 32,000 prescriptions were written. We continue to examine how to resource and provide mail order pharmacy coverage to all of our Medicare eligible beneficiaries under the NMOP.

Because of the significant cost growth experienced in providing the pharmacy benefit, we will continue to monitor and seek more effective operations in this area.

Managed Care Support Contracts

The TRICARE Managed Care Support contracts are partnerships between the Department of Defense and private health care delivery organizations that significantly enhance our ability to offer a full range of health care services to beneficiaries eligible for care in the MHS. The contractors establish networks of civilian providers to complement our military physician and facilities network, offer wellness information, assist beneficiary families with health care referrals, process health care claims and offer other types of assistance. This year we will complete our initial round of contract acquisitions. The delivery of health care services under the first contract began on March 1, 1995. This year, we hope all of our 11 regions in the U. S. will have the TRICARE triple option benefit available to their beneficiaries.

Enrollment

In regions where we are delivering health services under a TRICARE Managed Care Support contract, the initial demand for enrollment has been very high. Across the country, nearly 1.5 million active duty family members and other TRICARE eligible beneficiaries under the age of 65 have elected to enroll in TRICARE Prime. This represents nearly half of the former CHAMPUS users whom we have targeted for enrollment. In addition, 84 percent of our active duty family members and 64 percent of other TRICARE eligible beneficiaries have a military Primary Care Manager, which helps us to optimally utilize the less-expensive direct care system.

Beneficiaries and military line commanders alike have asked for immediate and continuous enrollment for TRICARE Prime. In response, we are preparing a proposed rule to effect this change in the TRICARE program. Following public comment, we hope to implement it in the fall of this year. Continuous enrollment will allow beneficiaries to remain enrolled in Prime year after year without the hassle of annual re-enrollments. Immediate enrollment will ensure our beneficiaries' health care needs are covered from the time they sign up for Prime.

TRICARE Overseas

We are energetically involved in reengineering activities to provide the TRICARE benefit to our active duty members and families stationed overseas. Our first overseas efforts were in the European Theater. The dramatic downsizing of the U. S. Forces in Europe led to significant changes in our peacetime health care support, especially for non-active duty beneficiaries, and to mounting concerns regarding access to needed health care services overseas. In response, we initiated an intensive TRICARE Overseas Program to ensure that our Service members, their families, and others who support the overseas mission, are provided quality accessible health care regardless of their location.

We have undertaken a number of initiatives to improve and standardize access to health care in our TRICARE Overseas Project. The TRICARE Europe program, which also includes Africa and the Middle East, and the TRICARE Pacific program are already

in place; TRICARE Latin America is currently under development. Our overseas program offers two health care options: TRICARE Prime and TRICARE Standard. TRICARE Prime services are available to all active duty personnel and to active duty family members who choose to enroll. The benefit is the same as the TRICARE Prime program in the United States, with the added benefit provided by waiver of copayments for active duty family members who must obtain care from host nation sources.

The introduction of a TRICARE benefit overseas has increased the accountability of our hospital and clinic commanders for all care delivered, whether in U.S. facilities or in the host nation medical facilities. To assist with this effort there are unique programs and services designed to better integrate the two systems:

- **Preferred Provider Networks**: An essential element of the overseas program is the establishment of formal relationships with host nation providers. Our regional offices establish the qualification criteria, and in-turn the host-nation providers agree to see U.S. patients, with no advance payment, and to file the claim on behalf of the patient. In Europe, over 2,000 preferred providers, both individual providers and institutions, are now part of our network.

- **Patient Liaison Services:** Throughout the overseas areas, we have added bilingual staff to assist our patients who require host nation care. If our personnel are hospitalized, the patient liaisons visit them daily and provide interpreter services as needed.

- **Document Translation:** We have awarded contracts to ensure important medical documents are translated into English and placed in the permanent medical record of our enrollees.

- **Health Care Information Lines:** We have introduced 24 hour, 7 day/week toll-free health care information lines which allow overseas families to call and speak to a nurse in the United States to discuss medical problems and seek health care advice.

- **TRICARE Service Centers:** The "one stop shop" for all medical needs, to include enrollment, network referrals, liaison services, claims processing assistance, and advocate services.

- **Technology Support:** Telemedicine capability is available to our overseas beneficiaries. Internet home pages have been established to improve communications with personnel overseas, and those enroute. Toll-free telephone numbers have been established to simplify enrollment and disenrollment processing.

We initiated an ambitious program to improve access to dental care for family members residing in overseas areas. The Overseas Family Member Dental Program

began in late 1994, is well underway in Europe and the Pacific and now is nearing completion. It is considered one of the single greatest quality of life improvements for our family members overseas. Efforts are underway to expand the TRICARE Active Duty Family Member Dental Program Overseas. This would permit enrolled family members overseas to obtain the same basic dental benefits now offered to enrollees in the TRICARE Family Dental Plan in the United States, where available. Services will either be provided in the direct care system, or if unavailable, the family member will be referred to a host nation provider identified by the local MTF commander who meets accepted U S dental practice standards. Efforts are underway in several overseas commands to identify dental providers who are qualified and willing to participate. This would allow us to provide dental care for an even greater number of personnel and to also facilitate access to dental care when beneficiaries are traveling in the United States.

Geographically Separated Units

We have been exploring alternatives for providing an equitable health care benefit for our active duty members and their families when they are stationed in remote duty locations within the United States. Many of these assignments are in areas geographically distant from our MTFs or TRICARE Prime sites. Active duty members are frequently required to travel long distances to MTFs for non-emergency care and their families must often rely upon standard CHAMPUS for health care coverage to a greater degree than active duty families who live near MTFs.

Building upon our experiences from the pilot project we instituted in Region 11, we began planning the expansion of this program last year. We modified our last two managed care support contract Requests For Proposals, for Regions 1, 2 and 5, to require offerors to provide the TRICARE Prime benefit to remotely stationed active duty members and their families.

As a result of the support and direction we received in the fiscal year 1998 Defense Authorization Act, we have begun a fast-track expansion of this program across the country. Working closely with our managed care contractors, Lead Agents and representatives from the Service Surgeons General, we are in the final stages of the contract modifications which will fully implement this important quality of life initiative. We are confident that this will enable us to provide most routine medical care near the active duty member's workplace, thereby reducing lost duty time, minimizing out-of-pocket expenses for service members, and improving continuity of care.

In conjunction with the managed care support contract modifications we are consolidating medical oversight of active duty medical care at the Military Medical Support Office in Great Lakes, Illinois. This office will give active duty members, managed care support contractors, and individual providers a single point of contact, available toll-free around the clock, to obtain assistance in coordinating active duty medical care from civilian providers.

Claims Processing Improvements

We have taken seriously the concerns expressed by our beneficiaries and civilian providers regarding the complexity of requirements for processing health care claims under TRICARE as compared to claims in the private sector. We have discussed these concerns with our managed care contractors to identify complexities that impact administrative costs and processing timeliness. As a result, we are making a number of policy changes to reflect our goal of reducing TRICARE claims processing data requirements.

To date, we have made significant progress through the new generation of TRICARE contracts, TRICARE 3.0, and the overall procurement process for our managed care contracts. For example, we have eliminated more than 400 edits, reduced the automated data processing (ADP) manual from about 1400 pages to 300, and identified 34 of the current data elements for deletion.

We are working to adopt the national standard eight-character provider identification number to be announced by the Department of Health and Human Services. Where possible, we are changing our standards and data requirements for TRICARE to mirror those required for the Medicare program. Finally, the requirement to use ClaimCheck software is slated for elimination. However, our contractors must implement processes to detect inappropriate coding and billing practices.

System Performance Measurements

A vital component of the strategic management and planning process is system performance. Measurements or metrics are necessary to determine if and how well strategic plan goals are being achieved.

In December 1995, specific health care delivery metrics were formulated. The purpose of the metrics was to provide our health care managers with tools to evaluate the effectiveness of the Military Health System (MHS) as DoD migrated into the managed care environment. The project that put the new metrics into operation is called the MHS Report Card. Report cards allow MHS corporate aggregate performance measures to be examined at the MTF level. This capability permits health care managers to compare the performance of one MTF against another or against the aggregate.

We have Report Cards for 150 military MTFs in the United States and overseas. The Report cards currently contain 35 active measures on Access, Quality, Utilization, and Health Status. Measures include satisfaction with access and quality, health screening indicators, JCAHO accreditation status, bed day and preventable admission rates, and the status of medical readiness trained and certified personnel. The Pap smear and mammography measures mirror Health Plan Employer Data Information Set (HEDIS) measures. At present, we are not collecting the information for some of the defined metrics because supporting data are not yet available. These metrics include the

status of active duty dental readiness, childhood immunizations, and three smoking and alcohol health behavior measures.

The first version of the report cards went to the Surgeons General in August 1996. Subsequent releases include data on trends in performance. We update customer satisfaction with access and quality monthly. The DoD aggregate in the December 1997 release shows—

- Improvement in 16 of 35 measures and no major change in 19 of 35 measures
- Goals met in 14 of 35 measures, ten measures are marginal with seven showing a positive trend towards the goal, and none trending away from the desired outcome
- Goals not met in 11 of 35 measures, three showing a positive trend towards desired outcome and none showing a negative trend

Report cards are an evolutionary tool. Future initiatives will incorporate ambulatory data, status of dental readiness, childhood immunizations, and the three smoking and alcohol health behavior measures. Additionally, we will incorporate civilian standards that will allow a comparison of MHS care to civilian industry benchmarks.

Health Care Reengineering

Historically, each Service conducted its own program of developing and implementing change. This perspective existed until the spring of 1996. Because of the amount of change occurring within the MHS and the rapidity of that change, we instituted a new and different approach.

The MHS health care reengineering effort now addresses organizational performance across the spectrum of continuous improvement to business process reengineering. The focus is on all levels of the organization—from within the military treatment facility to the Service to the entire MHS as well as the interactions with other Departments and agencies.

Our health care reengineering efforts are focused on our five strategic goals for the MHS. For example, under Force Health Protection, we are developing processes and systems that will identify, capture, and transfer health information on service members from induction to the Service through retirement and separation to the Department of Veterans Affairs (DVA) health system. This effort touches each of the strategic goals and incorporates a collaborative effort between Health Affairs, other DOD organizations, the DVA and other federal agencies.

MHS-wide reengineering activities include programs such as TRICARE and Medicare Subvention. However, health care reengineering also focuses on improvements at the point where care is given—in the military treatment facility. Over 350 initiatives from individual facilities or regions have been received and shared. Many of these

initiatives contributed to continuous improvement within the military treatment facility improving the services provided and streamlining processes. We continue to pursue methods and vehicles to tap into the experience and knowledge resident within the MHS and make it available where and when needed.

An adjunct program initiated this year was the MHS Commercial Activities Program. The Military Health System is consolidating and resizing its infrastructure in line with guidance provided by the Defense Reform Initiative. With establishment of an MHS Commercial Activities (A-76) Program all medical services are being reviewed for their competitiveness with private-sector providers. Currently under study for possible outsourcing is the Third Party Collections Program. Future patient care services to be reviewed include clinical pathology, nutritional care, and pharmacy. The objective is to improve cost effectiveness and the quality of care delivery.

DoD/Department of Veterans Affairs (DVA) Sharing

Since 1982, DoD and DVA have had agreements to share a wide range of health services. Last year, there were 751 agreements covering just over 6,000 services. Additionally, there are four joint ventures in operation and four in planning.

In October 1995, as a part of his Reinventing Government II (REGO II) initiative, Vice President Gore requested that a joint DoD/DVA study be conducted to identify ways of integrating the two Departments' health care systems to reduce government costs and increase beneficiary satisfaction. The report, sent to the Vice President in May 1996, identified several initiatives in which it appeared that mutually beneficial integration could take place.

Early this year, with the Under Secretary for Health, Veterans Affairs, we formed a DoD/DVA Executive Council comprised of senior health executives from both departments. The Executive Council monitors implementation of the REGO II initiatives and also develops and implements new, more efficient health system models. The council has laid out a fast track for implementation of its key initiatives:

Medical automation and technology. DoD and DVA have joined in medical automation research in DoD's Information Research Center. To date, they have linked DoD's Composite Health Care System (CHCS) and VA's Veterans Health Systems & Technology Architecture (VISTA), successfully tested clinical laboratory data exchange, and are accelerating the evaluation of off-the-shelf software in the automation of patient records. We have also agreed to pursue joint purchase of future health information systems, including a computerized patient record (CPR).

Standardizing disability discharge physicals. We will now give service personnel a single separation and disability physical. When separating and applying for disability, service personnel have been required to take both military separation physicals and DVA

evaluation physicals. Implementation of a standardized disability discharge physical was announced in a joint press release on December 4, 1997.

Assisting DVA to become a TRICARE network provider. DVA medical facilities are now eligible to be TRICARE providers. We negotiated a Memorandum of Understanding that authorizes our managed care support contractors to include DVA medical centers in provider networks. DVA rates have to be competitive with other providers. DoD also has developed special licensing arrangements for VA providers, and developed a modern cost accounting and billing system. As a result of this cooperation, DVA has successfully negotiated agreements in every TRICARE region.

Designation of certain DoD/DVA medical facilities as Specialized Treatment Centers of Excellence. DoD and DVA are designating certain select medical centers as Specialized Treatment Centers of Excellence. We agreed on spinal cord injury, blindness, amputations and traumatic brain injury specialties. This concept requires that patients needing these specialties be treated at the designated centers. It most efficiently uses the best of existing DoD/DVA specialized services capability and, at the same time, maintains the highest quality of care.

FEHBP and the Military Health System

As you can see, Mr. Chairman, this is an exciting time for the Military Health System:

- The worldwide implementation of TRICARE, DoD's new health care program, is nearly complete. Active duty members, their family members, and retirees, their family members and survivors who are under age 65 have excellent, affordable "managed care" and "fee-for-service" health plans from which to choose.
- DoD and the Health Care Financing Administration are launching the TRICARE Senior demonstration, authorized in the Balanced Budget Act of 1997. The demonstration will test the ability of DoD to operate as a Medicare+Choice plan, receiving capitation payments from the Medicare Trust Funds for enrolled beneficiaries. This will enable the Military Health System to leverage Medicare reimbursement to expand its capacity to provide care for Medicare-eligible retirees and their families.
- The Department has made significant strides in ensuring strong consumer protections and enhancing access to high quality health care for its beneficiaries, both in military facilities and from contracted providers in TRICARE.

Future needs for wartime combat medical capability, and the infrastructure to support it, are likely to change dramatically in the future. This depends on the outcome of current discussions of the role of the military in the post-Cold War era and our efforts to prepare America's armed forces for an uncertain future. The Report of the Quadrennial Defense Review (May 1997), the Defense Reform Initiative (announced in November

1997), and the National Defense Panel's report "Transforming Defense" (December 1997) all point to significant change in military medicine in the coming years. The existing infrastructure of military hospitals and clinics worldwide forms the basis of a cost-effective, high quality health care system for these beneficiaries – the TRICARE system.

Several legislative proposals have been introduced to allow military beneficiaries to enroll in the Federal Employee Health Benefits Program or to conduct a demonstration program of FEHBP coverage. Some proposals would cover all beneficiaries other than active duty members, some would cover all retirees and their family members, and some would cover only retirees and family members over age 65.

DoD has significant concerns about a new entitlement to FEHBP for military beneficiaries. These concerns are in the areas of increased costs to DoD, to Medicare, and to beneficiaries; the potential loss of Medicare subvention, the keystone of Dod's initiatives to enhance access for over-65 beneficiaries, and the major threat that FEHBP poses to military medical readiness.

DoD has reviewed the results of two analyses of the Military Health System (MHS) and FEHBP conducted by the Congressional Budget Office, and the findings in the General Accounting Office report, "Military Retirees' Health Care – Costs and other Implications of Options to Enhance Older Retirees' Benefits" (June 1997).

In its July 1995 report, "Restructuring Military Medical Care," CBO evaluated alternatives to the current operation of the MHS. CBO focused primarily on a proposal to close all but 11 military hospitals, meet readiness training needs in alternative ways, care for active duty members in military or civilian facilities, and enroll all other military beneficiaries in FEHBP. CBO estimated the government cost of insuring DoD eligibles under FEHBP would range from $7.3 billion to $12.1 billion, depending on the level of government contribution to the FEHBP premiums. This includes increased Medicare trust fund expenditures estimated at $1.4 billion. CBO concluded that, given government and beneficiary premium contributions commensurate with those for civil service non-postal employees and annuitants, participation rates would range from 37 percent for family members of retirees under age 65 to 95 percent for Medicare-eligible beneficiaries.

The key implication of CBO's 1995 analysis is that replacing the peacetime military health benefit with FEHBP would result in a net added cost to the Government -- unless there is a major cost shift to beneficiaries. Average annual out-of-pocket costs per individual are about $1,250 under the most widely used FEHBP plan, Blue Cross and Blue Shield standard option. A comparable figure for TRICARE would range from $100 to $500, depending on beneficiary category and option selected.

In January 1998, CBO provided cost estimates for several bills that would provide coverage for certain MHS beneficiaries. Because of the provisions of these bills, CBO took a different approach than in its 1995 analysis: FEHBP is considered as an additional

choice for beneficiaries, rather than as an alternative to existing coverage. CBO concludes that, given government and beneficiary premium contributions commensurate with those for civil service non-postal employees and annuitants, participation rates would be about 70 percent for beneficiaries over 65, about 5 percent for retirees, their families and survivors under 65, and nil for active duty families. These participation rates reflect the availability of cost effective alternatives to FEHBP. Overall, CBO estimates the net cost of offering an FEHBP option at about $2.1 billion annually. Most of this cost is attributed to Medicare-eligible beneficiaries, because CBO expects very low participation by other MHS beneficiaries.

These two analyses by CBO delineate two extremes: the 1995 report provides a high estimate, based an assumption that the MHS will be unavailable, and the 1998 report provides a low estimate, based on expected beneficiary response to an FEHBP option offered in addition to current options.

In its June 1997 report, the General Accounting Office assumed that 83 percent of Medicare-eligible retirees and family members would enroll in FEHBP if offered the choice, and estimated the cost to DoD at $1.6 billion. GAO did not estimate the cost to the Medicare Trust Funds of offering FEHBP.

In addition to the issue of cost, DoD has concerns about the military readiness implications of offering an FEHBP entitlement to MHS beneficiaries. These impacts would be exacerbated if the CBO's alarming estimates for the costs for an FEHBP option prove accurate, and some of the costs must be borne out of the existing Defense Health Program. The inseparability of the twin missions of military medicine is, simply stated, the ability to care for the men and women of the uniformed services through a continuum of operations reaching from the "boots on the ground" to installations here in the U.S. A vital, and unique component is the ability to assess health risks associated with ongoing worldwide deployments. The MHS must have physicians, nurses, technicians, and medics who know what to do to save lives and prevent illness and disease. They learn how to operate in a field or shipboard environment by working within that military setting, and they maintain their professional, technical skills by working in a military medical setting. We need hospitals and clinics where our health care personnel can practice and provide a highly valued benefit to the families of our active duty personnel, our retirees and their families.

If substantial numbers of beneficiaries are removed from the Military Health System, then DoD's ability to recruit, train, and maintain the needed medical force could be seriously impeded or disrupted. Existing training programs in military facilities may be unsupportable; new arrangements with civilian facilities for training military personnel would have to be made. There are considerable overlaps in the resources needed to treat seniors in peacetime and the casualties of war – from intensive care and operating rooms, to radiology and pathology services, to physical therapy and dialysis. Keeping these resources on standby for war is impractical; using them to support peacetime care for military beneficiaries is the sensible approach.

DoD is committed to the improving the military health system. Health care is an important aspect of quality of life, and DoD is committed to ensuring the quality and availability of medical care for all members of the military community including active duty personnel and their families, and retirees, their families, and survivors. FEHBP presents an alternative health care delivery option that could threaten the viability of our medical readiness infrastructure and would be dramatically more expensive for the Government and for beneficiaries than TRICARE for CHAMPUS-eligible beneficiaries and TRICARE Senior for Medicare eligibles.

TRICARE Senior and FEHBP

Mr. Chairman, I want to address specifically the issue of access to health care for military beneficiaries over age 65. TRICARE will always be incomplete until we have the capability to enroll retirees over the age of 65. Within the continental United States, our retired beneficiaries, their families and survivors are eligible to receive health care benefits under the Medicare system when they become 65 years of age. They continue to be eligible for care in the MHS on a space-available basis, but they are no longer eligible for care under CHAMPUS and therefore, are not eligible to participate in the TRICARE program. Medicare reimbursement to DoD is the key to alleviating the access-to-military care problem for our Medicare-eligible population.

Access to military health care is a benefit these people have earned based on their years of service to and sacrifice for their country. DoD feels a sincere and enduring responsibility for the health of our retired beneficiaries, and will do all it can to meet its moral commitment to provide health care for our military retirees and their families. At the same time, they understand the reality of fewer hospitals, fewer physicians, and less money. We are committed to finding the best alternatives for ensuring our older retirees and their families comprehensive health care delivery.

Our highest priority for keeping our commitment is TRICARE Senior. DoD worked closely with the Congress to achieve the Balanced Budget Act of 1997 provision authorizing a three-year demonstration of Medicare subvention, in which the Medicare program will treat the MHS similarly to a risk-type HMO for dual-eligible Medicare/DoD beneficiaries. The goal of the demonstration, TRICARE Senior, is to test cost-effective alternatives for delivering accessible and quality care to dual-eligible beneficiaries that does not increase the total federal cost for either agency. The legislation also authorized Medicare HMOs to make payments to DoD for care provided by MTFs participating in the demonstration to HMO enrollees. This part of the demonstration, called Medicare Partners, will allow DoD to enter into contracts with Medicare HMOs to provide specialty and inpatient care to dual-eligible beneficiaries.

We believe that working closely with the Medicare program, alternatives can be developed which will offer comprehensive, as-needed, health care for our older beneficiaries. The demonstration of TRICARE Senior is an important first step.

DoD is committed to finding ways to increase its capacity to provide health care to Medicare-eligible military retirees who live away from military treatment facilities, through expansion of the TRICARE program, through national implementation of TRICARE Senior, and through support for Medicare reimbursement for the Department of Veterans Affairs.

In addition, DoD will work with the Office of Personnel Management and Congress on a test of FEHBP coverage for military beneficiaries over age 65 with the understanding that any demonstration should be conducted in several locations outside military medical treatment facility catchment areas, and that additional funding for the demonstration be provided. The General Accounting Office report, "Military Retirees' Health Care – Costs and other Implications of Options to Enhance Older Retirees' Benefits" (June 1997) assesses several of the options, including a pharmacy benefit for seniors and offering TRICARE as a secondary payer to Medicare.

In summary, DoD has major concerns about the cost of FEHBP, and about its implications for TRICARE Senior, medical readiness, and force protection. Instead, DoD recommends full deployment of TRICARE Senior, which is being tested at six sites in a joint demonstration program with the Department of Health and Human Services.

Thank you.

Mr. MICA. Thank you.

I was interested in one of your comments toward the end. You said that any action by Congress to make a change here might dismantle health care for our active military. Is that the implication?

Mr. CHRISTOPHERSON. That's the part at risk.

Mr. MICA. I don't quite understand that statement. How is making access to FEHBP going to threaten the system—how is it going to do it?

Mr. CHRISTOPHERSON. Let me try and walk you through. Again there's a couple of different scenarios.

Mr. MICA. You went through under 65, over 65, dependents. But I just don't know—I'm trying to figure out how that's going to dismantle our current system.

Mr. CHRISTOPHERSON. Let me walk you through the problem here. The way the system works, if, for example, today we added over 65 FEHBP beneficiaries and gave you that choice and a significant number of new people come in, again you can look at varied estimates about what that would do, what that does that means it creates—and we do not have new resources which again is probably still the best current estimate of what's going to happen—what that does is, first, people we have to go into FEHBP, we have to pay that bill, that becomes a must pay bill. It's essentially an entitlement.

What that then does, that draws people that are currently in space available, over 65s and potentially under 65s, we have to reduce that down to pay that FEHBP bill. What that does again, it starts to create a cascading effect where everybody essentially goes to protect themselves and moves into either FEHBP or CHAMPUS, and you get to the point where essentially you have either people all outside the system, there's no patients being left inside the system because they're trying to protect themselves for the coverage there, so what you end up is a system that can't sustain itself.

What is key about that to understand is we tried a long time ago the idea of essentially primarily just taking care of active duty. The quality of the physicians that were in the system at that time were not up to the standards that we believed were good for taking care of active duty or dependents, and we moved away from that system. The quality of physicians that you have now in the military system, are high quality and equivalent to the private sector. That's where we get them from.

And very honestly, that's what we're really trying to keep there. And from the point of not allowing this cascading effect to occur, protecting the active duty and the dependents, that is what we're trying to accomplish here.

Mr. MICA. Wait a second here. We got TRICARE, TRICARE extra, TRICARE standard, TRICARE prime, and then there's this new TRICARE remote.

Mr. CHRISTOPHERSON. TRICARE remote, that's specially designed——

Mr. MICA. How many folks do we have in each of these categories?

Mr. CHRISTOPHERSON. Again people are in all those categories, except for the people over 65. That's the 1.2 million who could not sign up for TRICARE. They only——

Mr. MICA. A total of 1.2 million in all of them?

Mr. CHRISTOPHERSON. No, I'm sorry. We have a little over 6 million beneficiaries who are users of our system in the one way or another.

Mr. MICA. Six million.

Mr. CHRISTOPHERSON. Six million. That's right.

Mr. MICA. And TRICARE remote is an HMO type operation. How many folks in that?

Mr. CHRISTOPHERSON. That's a program that is just being tested out in Region 11, which is the northwestern part of the country. It is not being used with the rest of the country. The idea there is try to get the HMO, your enrolled care out into remote areas, as far out as we can try and do that, and protect the beneficiaries that can't sign up there; for example, recruiters and people in those areas, and protect the cost sharers.

Mr. MICA. So you think things are so bad that everybody would flee the ship?

Mr. CHRISTOPHERSON. No. What I'm saying here is what you have is this cascading effect of people trying to protect themselves. You move them out of space available care, and you force them out into either FEHBP and CHAMPUS, because they're trying to make sure they can protect their benefit.

Mr. MICA. We're not talking about pushing them out. We're talking about giving them a choice. Has the military ever done a survey of folks and asked them if they were given a choice or asked an evaluation of the current system, have we done that?

Mr. CHRISTOPHERSON. We have not done a survey.

Mr. MICA. I think that would be a helluva good idea. Because everywhere I go lately, I'm on the National Security Oversight Subcommittee, which is my second assignment on Government Reform and Oversight. And last Thanksgiving, I was in the Mideast and visited all the bases on force protection which we've been working on. I didn't hear a good word about TRICARE or the health care from any—I'm trying to think of anyone.

I mean it was my No. 1 complaint. I was on a submarine with the Secretary of Navy for a day off the Florida coast, and I went down to the little rec room they had there. I was asking the younger folks, I guess they were enlisted at that rank, about their concerns. Very great dissatisfaction, particularly regarding dependent care with the way folks are being deployed today in all these different situations. We've got them in 30 deployments, or whatever it is, around the world. And their families are left without adequate access to care. I've heard it everywhere, and it's becoming more and more of a concern.

Mr. CHRISTOPHERSON. An important piece of information, we do a national customer satisfaction survey based upon people who use our system there. If you looked at the results of those surveys, and we can make those available to the committee, we essentially have the satisfaction levels that equal or exceed what is the rest of managed care in the United States.

We use the same mechanisms as the private sector, the same measures and survey tools. Are there people who are unhappy with TRICARE or the military treatment facilities or the private contractors? The answer is, of course. Any large system of care is

going to have significant numbers of people who, at any given point in time, have problems, in the same way if you looked at any given point of view, you are going to have people who are not treated as well as they should be, like the witnesses in the previous panel. We acknowledge that. You have to look at a system of care as you do with any other, whether Blue Cross accessing the private sector or Kaiser, and I am in FEHBP. Kaiser is the organization I use as my HMO there. By the way, I wouldn't have any trouble shifting over and using TRICARE as my system of care.

I think if you look at the system of care with the qualities out there—similar standards, customer satisfaction. If you look at those objective standards based upon the beneficiaries, we are looking to be a pretty good system that is getting better, but we have work to do. We acknowledge that.

The question is TRICARE in its early stages, the answer is absolutely, yes. We have two contracts that haven't stood up yet, that won't stand up until May or June of this year. We are working on other things.

This issue of the over 65, that is coming at a time when we are essentially transitioning ourselves from a fee-for-service episodic system, clearly inadequate, to a system that says the first time you, the primary care manager in a military treatment facility or out there with one of our contractors, you have the responsibility for those beneficiaries, you take care of them and we will monitor.

What TRICARE is trying to do is shift ourselves to a system better or equal to the standards of care in the country.

Mr. MICA. Mr. Simmons did a little simple math on some of the figures and cost. Maybe you could comment. He actually felt by shifting away from TRICARE and shifting to FEHBP, that we could save money. What do you think?

Mr. CHRISTOPHERSON. We looked at that and obviously the Congressional Budget Office has looked at that as well. And very honestly, I have done a fair amount of work in my several years work with the Department, is to really say is this the way to go. Are we serving the Federal taxpayer well? And one of the things that we did look at was cost, and GAO has looked at costs as well.

The general feeling that we have right now is because of things—for example, we can buy pharmaceuticals cheaper than other people can. We have certain purchasing power, which FEHBP has part of that as well, that we actually can produce essentially the same level of service for a slightly lower cost. It is not a huge difference. It is not a huge savings between FEHBP and the TRICARE system, but there is a slightly lower cost. We have certain investments in facilities that we can keep the cost down as well.

So if you look at it, we believe that we can do it for a slightly lower cost, but the cost is not the huge issue until you get to the issue of over 65, where you are talking about beneficiaries which have not been covered beneficiaries under either system during the period. That is a very different issue.

Mr. MICA. I'm curious, back to Mr. Simmons and his math, he took the total figure and divided by the number of people it would serve and came out with a figure. If you can provide the numbers for our subcommittee, I would like to know how much DOD spent on these various TRICARE programs? And if you could include a

portion for administrative overhead, contract costs in fiscal year 1997 or the most recent fiscal year. I don't know if you have those figures.

Mr. CHRISTOPHERSON. We will provide you those figures.

Mr. MICA. I think it is important that we get some measure of the cost and maybe do a little simple math, maybe a little more complicated. I'm still not certain that allowing access to FEHB would dismantle the system.

I thought I heard in your testimony one of the reasons that we haven't been able to pass my bill or any of the other bills, which is primarily the objections of the Department of Defense. We are fighting a very big agency with a lot of firepower.

Did I hear a glimmer of concession or interest in a demo project in your testimony? Did I hear you say that if we did this on a limited basis, some of the constraints in the Watts bill or my bill as proposed, the Department of Defense might buy off, checkoff?

Mr. CHRISTOPHERSON. Two things. One, I was making the point without doing some kind of demonstration effort it is very difficult to go forward on something that has a potential magnitude of several hundred million to a billion with unknown effects in terms of the system care.

On the issue of the demonstration, doing a FEHBP or some combination of demonstration kind of projects there, we have indicated in the past that we do not object to it. Dr. Joseph indicated in some testimony. We have taken essentially the same position to date.

I think the key in terms of doing that is making sure that your testing models that are really viable options and, second, someone has to figure out how to pay for it because a number of the demonstration programs proposed ranged from $60 million to $160 million a year, which is a pretty good sized demonstration.

Congressman Watts' bill is a phase-in of FEHBP and is a different kind of demonstration program. Again we talked about at least $100 million the first year and see how that plays out over 1, 2, 3 years.

Again, we have indicated that we do not object to the demonstration project, but we want to make sure that we are in agreement where this is taking us. Sometimes it is easy to get people to agree on a demonstration project and never have the intention of following through later on, and I think we have to be up front in that we address the question of resource dilemma. I think we have to deal with that or the demonstration is not going to accomplish very much.

Mr. MICA. In developing a policy with an endorsement of the demonstration project, if it were to get this in place on some acceptable basis, you're just acting——

Mr. CHRISTOPHERSON. Correct.

Mr. MICA. Who is going to make the decision? This is the Secretary and who else?

Mr. CHRISTOPHERSON. In terms of whether or not to do a demonstration project, that will be essentially a major level department decision. The Undersecretary will participate in that discussion with us. Because of the long-term implications, these kinds of issues will involve the Deputy Secretary and others before all is

said and done. Again, you are talking about—it is not because of the demonstration per se, it is the issue of the implications.

Mr. MICA. Again you spoke today and said that the Department might support a demonstration project.

Mr. CHRISTOPHERSON. Again, I indicated we would not oppose it. That is the clear position there. What I will indicate, we have been working with our authorizing committees, we have done some work in terms of what they are trying to look at in the demonstration bill.

Part of the difficulty, especially for the Department, the old days of the Department of Defense having oodles of money and keep getting money seems to not be there any more. And you talk around to people, and we have talked to people in Congress and said what do they think of the chance for additional money, and the answer is unlikely.

And I think that is partly why you see the Department being very nervous because there is pressure in other areas like modernization, and so it has competing demands on a scarce number of dollars. That is probably an unusual statement——

Mr. MICA. The other thing, you talked in your testimony about the question of cost shifting, and some of this is—I mean, you are going to pay for some of those folks in TRICARE. We haven't determined whether that is more costly than putting them in FEHBP.

But if we could find that there is some savings or there is some equity in bringing them over, we might take pressure off TRICARE. If there is consent on a demo basis, we may not dismantle health care as you know it for the active military.

The other thing that concerns me is that when you go back to the testimony of Dr. Glacel, when she finally could get care it seemed to be of fairly decent quality, although there are other questions about doctors dropping out of TRICARE and not participating or no access. But it seems to me that we could allow people that choice of accessibility, and maybe the convenience in a system that again offers some proven success to provide health care. Do you go along with that?

Mr. CHRISTOPHERSON. We have indicated for quite some time and I have looked at a lot of different models about how we best provide care. What I do as the Acting Assistant Secretary or my other role, which is the principal Deputy Assistant Secretary, is how to balance the mission that we have to try to deliver on, the missions for both. We take our commitment to the beneficiaries very seriously.

Back to the question of FEHBP having a potential role, we don't know. We understand that clearly from the point of view of the beneficiary, a lot of beneficiaries—there is some of different views, but it is clear that having another choice is never really bad as long as it doesn't have any other bad consequences, so I think FEHBP is a good program and I have used it and I think it is a great program. The issue is more how do you figure out with scarce dollars to provide care to more beneficiaries.

Mr. MICA. If it doesn't cost any more or there is a cost savings and we can identify with that group and we can make them eligible and open it up, I don't see the big deal.

Now, the problem that I have is you come and you testify in support or say you are supportive. Who else do we need up the chain

of command to get a real decision? If we are going to cut a deal here with the National Security Committee to start a demo project, it is going to take your checkoff and the Secretary's checkoff, and who else?

Mr. CHRISTOPHERSON. In the first place, there are discussions in the House Security Committee and the staffs and the Senate Armed Services Committee. Everybody understands the concerns of the committee and the other committee.

Mr. MICA. Those who deal with it, tell me who on your side?

Mr. CHRISTOPHERSON. In the first place it depends on the budget implications.

Mr. MICA. We are going to identify something that is revenue neutral.

Mr. CHRISTOPHERSON. That was revenue neutral?

Mr. MICA. I'm not going to impact—in fact, I may promote this as a cost saver if I can get Mr. Simmons proven correct.

Mr. CHRISTOPHERSON. I think that would be difficult, but I will go along with you for the moment in terms of that.

Mr. MICA. We can find a small category that we will carve out as our demo basis.

But tell me now again because, you know, DOD is huge. It is bigger than——

Mr. CHRISTOPHERSON. It is good sized.

Mr. MICA. It is bigger than my committee or subcommittee staff. Tell me who am I going to have to deal with? There are you and the Secretary. Who is in between to make an honest decision of moving forward?

Mr. CHRISTOPHERSON. The chain of command is very simple. It goes to myself, it goes to the Undersecretary of Personnel on Readiness, who has the responsibility for benefits issues, and then it goes to the Deputy Secretary and the Secretary.

Mr. MICA. So four people in the feeding chain to get——

Mr. CHRISTOPHERSON. In the decision chain, yes.

Mr. CHRISTOPHERSON. That is it.

Mr. MICA. Well, the reason we are holding this hearing is to try to see if we can find some basis on which we can institute this reasonably.

I have no problem, if I'm going to vote and we have an $18 billion budget surplus, one of my top priorities, if it was to spend a hundred million now, that is nothing. It is nothing out of that surplus, it is nothing out of your budget, and I tend to think you are serving many of those folks anyways, and we can probably do it at the same cost or close to it, and we can dispute that later on.

Mr. CHRISTOPHERSON. Two points, Mr. Chairman. Under 65 is sort of one discussion.

The over 65 is clearly—I don't think there is any disagreement—it is a new resource. We are spending about $1.2 billion now for over 65 care. The other decisionmakers, by the way, you are going to have to think about is Medicare. If we are talking about for the over 65 population, as the Congressional Budget Office indicated, there are at least two opportunities for Medicare impacts, one in terms of just providing a supplementary insurance plan, you increase your utilization.

The second is if I'm taking dollars currently provided today to pay for a whole hospitalization and instead it is a part of FEHBP, from Medicare's perspective I just shifted cost because they have to pick up the first payer portion of that. So I think Medicare has some thoughts about this as well.

Mr. MICA. And we are going to see what group we can start with and do it in a cost effective manner, and also hopefully address their health care needs. There appear to be some gaps in TRICARE. We want to do it without dismantling the health care system.

I have asked quite a few questions. I have been joined by Ms. Norton. Ms. Norton, do you have questions?

Ms. NORTON. I regret I was not here for the testimony of the prior witnesses. I especially wanted to hear the testimony from witnesses who have been involved in the health care dilemma proposed by today's hearing.

I simply want to thank you for calling this hearing. It may not be the top of the agenda for many Americans because it involves relatively few people, but they are people who are operating within a system that very much needs to be fixed. Some would go so far as to say it is a broken system, and particularly given who are involved, they are broken promises of our country.

We do find a terrible dilemma, a dilemma of care and of costs to try to fix the system because as I have looked at various approaches that have been offered, I am the first to concede that none pops up as the deal and magic answer.

I am on two of the nine bills that have been proposed. One is a bill authored by Republicans and the other by a Democrat, Mr. Moran. As that might indicate, this does not divide itself easily into Democratic or Republican solutions. The system in which the constituent—our constituents have been caught is—is built over time.

I must say that as I look at the various approaches and looked at your testimony before coming this afternoon, Mr. Chairman, I am inclined to believe that when you consider how complicated this matter is that your notion of a demonstration project is probably wise.

We will make fewer mistakes trying to solve a complicated problem if we take it one step at a time and iron out our mistakes one step at a time.

I want to encourage you to continue in the path that you've chosen to try to get our feet wet instead of leaving this problem hanging out there very unfairly. It is to us whom our constituents and the American people should be looking for solutions.

We put the agencies in a terrible dilemma if we ask them which way to go, so to the extent, Mr. Chairman, that you are moving toward getting some kind of consensus agreement on an approach that would instruct us, do a demonstration project as to how to fix this very complicated matter, I want to endorse what you have said during the time that I have sat here. Thank you very much, Mr. Chairman.

Mr. MICA. Thank you, Ms. Norton. We are going to try to use a carrot and a stick. We are going to do a letter first to leadership and Appropriations and Budget and National Security chairs. And then we will bring out the 2 by 4 if we have to, but we are going

to try to work very gently and cooperatively with our leadership because there is overwhelming support.

Mr. Moran has 240 signatures on behalf of nine bills, I believe, and he has unanimous consent to move on this if it comes to the floor. If not unanimous consent, I think we have 218 votes and that beats the best argument in the House. So we are going to move forward on this.

We hope you can take that message back to the Secretary and to other individuals who will help make the decision. We are willing to work with you to begin to identify a group that we can make FEHB available to. I think you told me there are 8 million involved.

Mr. CHRISTOPHERSON. We have 8 million total beneficiaries, 6 million actually——

Mr. MICA. 100,000 or 200,000 is not going to bring down the system. Again, working together I think we can find some basis to take some pressure off of TRICARE and also fill in the gaps.

As we face additional base closures and changes in the structure of our military active force, while less and less health care for the military is available, it is a very serious problem. But, I think we can do this.

The staff prepared pages and pages of interesting questions which I will not publicly grill you with this afternoon, but we will submit additional questions for you to complete the record.

In the spirit of cooperation in letting you off the hook, I know that you are going to recommend to those others who make decisions full cooperation with us to get this job done.

Mr. CHRISTOPHERSON. We always look forward to working with the Congress.

Mr. MICA. I was hoping you would just say "yes."

We do want to thank you for being with us this afternoon. I also have a unanimous request to submit for the record the statement of Edith G. Smith, a citizen advocate for disabled military retirees.

[The information referred to follows:]

My name is Edith Smith. I am pleased to submit my statement for the record to The Members of The Civil Service Subcommittee of The Committee on Government Reform and Oversight, United States House of Representatives, at a Hearing regarding the military health benefit on April 28, 1998.

I consider myself to be a traditional military wife from Springfield, VA. I am a volunteer citizen advocate and I represent no organization. My husband, Vincent M. Smith, and I became involved in advocacy work to correct the unjust loss of his CHAMPUS benefit in 1989. Vince was determined to be Social Security disabled in February, 1987, at age 49.

Twenty nine months later, my husband was forced to Medicare A. DoD then terminated his earned CHAMPUS benefit 14 years early as a defined "cost saving" measure. My husband qualified for Social Security Disability Income and Medicare under age 65 through Social Security contributions made solely by his civilian employer of over 6 years following his military retirement from 21 years honorable service in the United States Marines Corps. How can DoD force the substitution of a benefit earned through civilian employment (Medicare) for a benefit of military retirement (CHAMPUS)?

This unjust loss of my husband's earned CHAMPUS benefit has caused us to join others in working to correct this inequity for all military beneficiaries who are at risk of severe disability or End Stage Renal Disease (ESRD) under age 65. Efforts initiated by Congressman Bill Young, FLA., and Senator John McCain, AZ, quickly restored CHAMPUS as second payer to Medicare A and B for retired beneficiaries under age 65 in 1991.

I would like to present my views on the military health benefit as uniquely provided to military retirees and their family members who become eligible for Medicare under age 65. I believe the Department of Defense has interpreted and implemented these laws in the most restrictive budget sense for the system, and without regard for fairness and equity to beneficiaries. I have particular concerns regarding the failure of The Department of Defense to complete the implementation of various laws, regulations, or policies affecting this unique benefit for the disabled. Congress passed these laws as critical protective measures to assure the disabled retired military beneficiaries would receive no less retired medical benefit than others simply because of their misfortune to suffer disability or ESRD.

The requirement to enroll in Medicare Part B coverage is an unjust, discriminating, and additional requirement of TRICARE eligibility for disabled retired beneficiaries. If no other beneficiary enrolled in TRICARE is required to purchase other health insurance for which they may be eligible, why does the Government insist on this seemingly unworkable Part B requirement solely for the most needy military retiree under age 65? Medicare Part B enrollment is not required of disabled retired Federal Civilians to maintain their eligibility for FEHBP. **The disabled retired military beneficiaries are unhappy with this unique "second class status" and most would be better served by a voluntary option to participate in the Federal Employees Health Benefit Program (FEHBP) that is provided to Congress and the Federal Civilian workforce.**

Congress appropriates about $4 billion annually to meet the government's contribution to the Federal Employees Health Benefits Program for 1.8 million retired Civilian annuitants. The Military Health System provides only $1.2 Billion to provide "space available" medical care for about 300,000 Medicare eligible retired beneficiaries in Military Treatment Facilities. How can the Congress ignore this egregious disparity between health benefit funding provided to the military retiree and the civilian annuitant? While some 30% of elderly retired military do access "free" medical care, the majority of military retirees over age 65 receive no medical benefit from their employer.

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ISSUES OF CONCERN FOR MILITARY MEDICARE ELIGIBLES UNDER 65

1. **DATA match** between Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Financing Administration (HCFA) was accomplished by DEERS on about March 19, 1998, as required by Sec. 734, FY96 Defense Authorization Act. DEERS courtesy information letters informing disabled beneficiaries of the termination of their retired eligibility TRICARE/CHAMPUS were mailed on March 20, 1998, to 12,093 beneficiaries who had not purchase Medicare Part B. 99,676 military beneficiaries were identified as eligible for Medicare A and TRICARE by the DEERS/HCFA match.

2. **DEERS inaccurately reflects TRICARE as primary w/o Part B-** It appears that DEERS did not update their computer records on March 20, 1998 to reflect Medicare A and B for individuals identified on the HCFA data tape when the match occurred. 12,093 disabled persons may now be erroneously listed in DEERS as primary TRICARE eligible. Some who have called for more information have been informally advised by personnel who depend on DEERS records to continue with needed medical care under TRICARE until DEERS records reflect their ineligibility for TRICARE pending anticipated retroactive legislative relief. DoD must document this situation or informal policy so that no disabled person who trusted government advice will later be at risk to suffer prosecution under TRICARE fraud regulations if other officials disagree with this policy at a future date in order to recoup TRICARE funds and balance the budget.

3. **Waiver of recoupment** for erroneous CHAMPUS payments for Medicare eligibles; FY96, Section 743, Not yet implemented - over 2 years later. Proposed rule published in Federal Register, December 4, 1997. An description of this provision was omitted from the DEERS letter mailed to disabled beneficiaries on March 20, 1998.

4. **"Equitable Relief" waivers** for Under 65's are the appropriate solution to this "no Part B" problem and must be approved for request by DEERS as discussed in a letter from Dr. Stephen Joseph, ASD(HA) to HCFA, January 16, 1997 (attach. #2.) **It appears that the rights of Medicare eligibles UNDER age 65 have been prejudiced by DoD's failure to accomplish a DATA match which has caused the unintentional, inadvertent, or erroneous nonenrollment by some beneficiaries in Medicare Part B.** "Equitable Relief" granted by HCFA would allow immediate or retroactive enrollment in Medicare Part B without premium penalties, thus quickly restoring earned TRICARE benefits to our most needy retirees. "Equitable Relief" is consistent with the spirit of forgiveness implied in the "Waiver of Recoupment" provision passed by Congress in 1995. For HCFA to deny "equitable relief" to these disabled beneficiaries who were not able to enroll in Part B would then be barred from Part B and TRICARE participation until July 1, 1999. This would mean a measurable savings to both programs of millions of dollars this next year.

5. **TRICARE eligibility requires unfair purchase of Medicare B.** I urge Congress to eliminate this discriminatory Part B requirement which makes vulnerable disabled beneficiaries under age 65 the only TRICARE beneficiaries required by law to fully participate in other health insurance for which they are eligible. Decreasing DoD staff should not be held responsible to perform additional tasks to develop the expanded administrative bureaucracy required by this new complex military health benefit.

BACKGROUND

This small group of disabled retired beneficiaries is unjustly denied equal eligibility for TRICARE/CHAMPUS. The disabled military beneficiaries have been cost shifted to the lesser benefits of Medicare A by entitlement, and to Part B by required enrollment with a 1998 premium of $43.20 @ mo., simply because they have been employed and suffer the misfortune of severe disability or End Stage Renal Disease (ESRD.) Active duty family members are shifted to Medicare Part A by entitlement, but they are not required to enroll in Medicare B to retain TRICARE benefits. Family members who may become disabled, and have not been employed, would not lose their primary TRICARE eligibility and be switched to Medicare. (They have not worked to earn Social Security Disability Income and Medicare benefits.) **Additionally, no other military beneficiaries are required by law to purchase other health insurance to which they may be entitled in order to save TRICARE money.**

Why then has Congress required the disabled beneficiaries to enroll in Medicare B? As DoD develops and expands their new managed care demonstrations and programs, the Medicare eligibles UNDER 65 appear to have been "cherry picked" and left basically alone to fend for themselves in a "no man's administrative land" of the dual coverage of Medicare and TRICARE.

Since 1973, when Social Security Law first entitled disabled individuals to Medicare A , DoD has recognized a need to coordinate a mechanism between DEERS and HCFA to identify and notify dual eligible military beneficiaries. (Attach. #1.) After 25 years, DoD accomplished the DATA match last month and identified 12,093 unique retired beneficiaries who had failed to purchase Part B. Under current law, these disabled retired beneficiaries are ineligible for TRICARE and complex Part B enrollment requirements will leave many without any outpatient coverage until July 1, 1999. "Equitable Relief" waivers based on error or inaction of the government to notify these beneficiaries of the requirements of law for CHAMPUS eligibility seems reason enough for DEERS to request, and HCFA to grant these waivers.

"Equitable Relief" waivers are critical for retired UNDER 65 beneficiaries because of the ability to enroll retroactively or immediately in Part B. Retroactive enrollment in Part B insures beneficiaries continuous EARNED retired eligibility for CHAMPUS/TRICARE coverage with reimbursement for any previous unpaid medical bills. The restrictive general open enrollment period for Medicare B (1 Jan - 31 Mar) causes a gap in outpatient medical coverage of up to 15 months for a disabled military retired beneficiary when they are restricted from using TRICARE because they are not enrolled in Part B.

Medicare OVER 65 beneficiaries who do not enroll in Part B do not fall victim to unpaid medical bills because after age 65 they are not reliant upon CHAMPUS for medical care. If OVER 65's failed to purchase Part B, they probably received their medical care from a military facility and are not subject to repayment of medical costs to private sector providers who treated them with good faith in their retired CHAMPUS eligibility.

"Equitable Relief" waivers requested by DEERS from HCFA on behalf of the unique dual eligible beneficiaries will be critical to permit continued TRICARE/ CHAMPUS coverage, an earned benefit of retirement, without lapse. Legislative relief to waive the Part B requirement temporarily, while welcome, still may leave unintended gaps in medical coverage. The legislation also ignores the spirit of forgiveness (implied by Congress) to waive the Part B penalties that have incurred because DoD/HCFA did not run the DATA match in 1991 when CHAMPUS was restored to these individuals.

Foreseeing this catastrophic situation the disabled would face when the DATA match was accomplished, Dr. Stephen Joseph, ASD(HA), wrote to The Administrator of HCFA in

January, 1997, and requested assistance in solving the problem unique to Medicare eligibles UNDER 65 resulting from the lack of a DATA match. (Attach. #2.)

The Health Care Financing Administration (Medicare agency) regulations HI 00830.001 -"Granting Equitable Relief", HI 00830.005 - "When to Consider Relief", HI 00830.010 - "Evidence Required", and HI 00805.236 - " Current Equitable Relief Consideration Involving CHAMPUS" describe HCFA's process "...to provide certain forms of relief to individuals whose SMI or premium enrollment or coverage rights have been prejudiced by the error, misrepresentation, action or inaction of an employee or agent of the Government..."

My testimony provides a DoD memo dated June, 1973, which documents DoD's need for a mechanism to identify Medicare eligibles under age 65 who are dually eligible for CHAMPUS. (Attach. #1) If a DATA match was deemed to be required and run on March 19, 1998, then this DATA match should have been equally important in 1973. The CHAMPUS eligibility situation for active duty family members had not changed since The 1972 Amendments to the Social Security Act provided Medicare for those under age 65 because of disability or End Stage Renal Disease. **Contrary to information in the recent DEERS letter, retired disabled military beneficiaries previously enjoyed dual eligibility of Medicare/CHAMPUS without the requirement to enroll in Part B from 1973 to December 13, 1980.** If DEERS has mailed courtesy letters to Medicare eligible at age 65 since 1986, then how can government officials from both DoD and HCFA be permitted to turn their heads and ignore an equal need to identify and notify this unique disabled population under 65?

I believe this travesty, leaving disabled military without outpatient insurance, is an unintended consequence of Federal Law requiring retired Medicare eligibles under age 65 to purchase Medicare Part B. I respectfully suggest that Congress direct the Department of Defense to revert to old DoD/HCFA policy basis for "equitable relief" for UNDER 65's that includes "error or inaction" on the part of DoD/HCFA employees who have failed to accomplish the DATA match for 25 years.

###

DATA MATCH BETWEEN DEERS AND HCFA TO IDENTIFY AND NOTIFY DISABLED MILITARY BENEFICIARIES OF THEIR UNIQUE CHAMPUS/TRICARE ELIGIBILITY REQUIREMENTS

Defense Acts, (not Social Security Laws) authorized this Part B requirement. Therefore, the Department of Defense must be held fully responsible and accountable to identify and notify disabled Medicare eligibles UNDER age 65 of their change in eligibility to TRICARE/ CHAMPUS the same as they have identified and sent written DEERS notification to retirees OVER 65 for more than 10 years. These DEERS letters are the only official personal notification Medicare eligibles would receive. Had the DEERS letters been issued beginning in 1973, these disabled military beneficiaries would have received appropriate information to prompt timely enrollment in Part B, possibly averting the lifetime Part B premium penalties of 10% per year associated with late enrollment.

The first DoD memorandum signed by Vernon McKensie, DASD (Health, Resources, and Programs), 25June1973, states a need for a "DATA match" with Social Security. To quote from the memo: **"We have not been able to complete the coordination with Social Security Administration which we feel is necessary to establish a final**

CHAMPUS implementation of the three new Medicare eligibility provisions of the Social Security Act of 1973 which provide Medicare eligibility for some CHAMPUS beneficiaries. Pending the completion of the necessary coordination of the CHAMPUS and Medicare claims procedures..." This coordination was never accomplished by DoD until March 19, 1998.

Determination of CHAMPUS eligibility status -- The CHAMPUS handbooks have traditionally stated CHAMPUS regulations place the responsibility on The Uniformed Service of the sponsor to decide beneficiary eligibility for CHAMPUS (1997 Standard TRICARE handbook, pg. 151) and to issue ID cards through the military personnel office of the sponsor's military service.

Evidence of eligibility. Chapter 1, Sec. 3.e., CHAMPUS regulations 6010.8R, -- "The Department of Defense, through the Defense Enrollment Eligibility Reporting System (DEERS) is responsible for establishing and maintaining a listing of persons eligible to receive under CHAMPUS. Identification cards or devices bearing information necessary for preliminary evidence of eligibility, subject to verification through the DEERS, shall be issued to eligible persons by the appropriate Uniformed Service (DoD 1341.1-M, ref.(e))."

DEERS is a self reporting system that holds the military sponsor responsible to update changes to his DEERS records. The Assistant Secretary of Defense (Health Affairs) reported to Congress on April 4, 1997, that 23,733 retired Medicare eligibles UNDER 65 have self reported their Medicare A eligibility to DEERS. (Attachment #3) DEERS has sent courtesy letters to these individuals explaining the unique requirements of their CHAMPUS eligibility. This letter, arriving after the fact, does nothing to inform the disabled beneficiary in advance of the past changes in their CHAMPUS/TRICARE eligibility to avoid penalties.

The military sponsor is responsible to update DEERS records to include Medicare eligibility. If DoD is not held accountable to disseminate information on this dual coverage, how can the affected beneficiaries be held responsible to know the law? When a disabled beneficiary declines enrollment in Part B, he often does so because he believes he is covered by CHAMPUS until age 65 as are all other retirees. He also erroneously believes that if he doesn't pay for Part B, then he is not enrolled, and does not need to report Medicare on his CHAMPUS form. After all, participation in Other Health Insurance is a voluntary choice for all other retired beneficiaries.

###

EQUITABLE RELIEF FOR MEDICARE PART B PREMIUM PENALTIES

The failure of DoD to previously provide DEERS courtesy information letters to dual Medicare/TRICARE beneficiaries should qualify as the "error, misrepresentation, or inaction of a federal employee which caused the unintentional, inadvertent, or erroneous nonenrollment by the beneficiary in Part B." 42 CFR 407.32. [DOD, Office of General Counsel's Opinion, December 21, 1994.]

Prior to 1996, when a military beneficiary attempted late enrollment in Medicare B, DEERS officials generally provided the necessary documentation to request an "equitable relief" waiver from HCFA by explaining that DoD had probably misinformed the retiree about this unique requirement to enroll in Medicare Part B as a condition to retain their military health

benefit. TRICARE/CHAMPUS does not provide each military beneficiary with a handbook as does Medicare and most other insurance programs.

Base closures caused many retirees who had depended on military medical care to apply for Medicare Part B with late enrollment penalties. This new influx of Part B applicants caused by base closure (most over 65) prompted HCFA to review sudden increased HCFA costs associated with granting "Equitable Relief" to these retirees. Maybe HCFA does not want to absorb additional costs to their programs resulting from downsizing the military.

This influx of Part B applicants caused DoD to tighten its policy traditionally used for providing "Equitable Relief" letters from DEERS for military beneficiaries seeking late enrollment in Medicare B. DoD then forwarded legislation (FY97 and FY98) requesting "equitable relief" for OVER 65's in Base Realignment and Closure (BRAC) sites with no explanation for omitting the Medicare under 65's in this legislative proposal.

Why would DoD exclusively identify BRAC site beneficiaries over age 65 to receive legislative relief from the Part B penalties? Most over 65 retirees would have received the DEERS courtesy letters explaining their personal risk to rely on "space available medical care" if they chose not to enroll in Part B. The official criteria for "relief" should be DEERS notification to a beneficiary by letter of the termination of CHAMPUS eligibility and the switch to Medicare. DoD's criteria for requesting "equitable relief" waivers must focus on the beneficiaries who were not informed by DEERS courtesy information letters of their changed CHAMPUS eligibility. The unique situation of failing to identify and inform UNDER 65's was not considered when the new DoD policy for "Equitable Relief" was written in May, 1996.

- **"OVER 65" Medicare-eligibles receive DEERS notification letters** shortly before their 65th birthday explaining the termination of their CHAMPUS benefit and how to proceed with the switch to Medicare. Why should Medicare eligibles understand the need to purchase Medicare B if they have used the Military Health System successfully for many years? This older generation has unwavering faith in a belief that they are "grandfathered" in the Military Medical System as promised by our government.
- **"Over age 21 and 23" dependent children receive DEERS letter** terminating their CHAMPUS benefit on their birthday.
- **"UNDER 65" Medicare-eligibles have <u>NOT</u> previously received DEERS letters of notification** as there was no DoD coordination with Medicare to identify these beneficiaries who are disabled or have End Stage Renal Disease until March 19, 1998. Since 1973, DoD has been aware of the need to develop a mechanism to notify Medicare eligibles and has failed to do so. (Attach. #1) Without "Equitable Relief" recommended by DoD, some beneficiaries are denied access to earned TRICARE/CHAMPUS for as long as a 15 month waiting period for Medicare enrollment in addition to the assessed stiff premium penalties for late enrollment. This unintended gap in medical coverage is life threatening to disabled individuals who would be forced to go without daily maintenance medications required to stay alive, as well as other Part B and TRICARE covered services.

<u>DoD must acknowledge and accept responsibility for error and inaction on the part of government employees who failed to develop a mechanism to inform retired CHAMPUS beneficiaries of their changed eligibility in a timely manner.</u> Had the DATA match been set up in 1973, the system would be working and each beneficiary would have received a timely letter of notification potentially averting penalties and a lapse of medical coverage when they need it most.

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TRICARE PRIME ENROLLMENT for MEDICARE ELIGIBLES UNDER 65
Eliminate Medicare Part B Requirement

I ask The Committee to please support the removal of the mandated requirement to purchase Medicare Part B as an unnecessary and unfair condition to enroll in TRICARE PRIME for the retired Medicare-eligible beneficiary.

DoD informational materials on TRICARE PRIME state that Medicare-eligibles may not enroll in PRIME at this time. "Medicare eligibles" unable to enroll are OVER age 65. Medicare-eligibles UNDER age 65 are eligible for TRICARE PRIME enrollment. TRICARE PRIME charts describing eligibility categories, enrollment fees, and copayments must be required to include unique Medicare-eligible requirements. DoD's explanation that the disabled group is too small or the dual coverage too complex to justify space in the marketing materials is not reasonable. TRICARE websites also have failed to adequately describe the requirements of Part B for unique beneficiaries.

I am told that TRICARE contractors and MTF Commanders are advised to discourage enrollment of beneficiaries with other health insurance, to include Medicare. However, Medicare differs from other major medical policies in that it does not include prescription drug coverage. How many military medical administrators know that an active duty family Medicare-eligible member is not required to purchase Part B. The retired beneficiary who has been employed is required the Part B purchase. A disabled family member who has not earned Social Security credits for Disability income retains full CHAMPUS eligibility until age 65 without the required switch to Medicare. Medicare eligibles at any age may enroll in the Uniformed Services Family Health Plan without the requirement to purchase Part B. More importantly, are the stiff penalties of failing to purchase Medicare B at the initial enrollment period fully understood and explained by Health Benefits Advisors or other TRICARE customer service employees?

The disabled military retiree may choose to sign up in TRICARE PRIME to free himself of paperwork that he may not be well enough to accomplish, or to save himself the 25% cost share for TRICARE prescription drugs and other preventive programs not offered by standard TRICARE. The disabled military beneficiary may simply desire to join fellow retirees and eligible family members in the Military Health System with merely a sense of belonging, or as a matter of convenience. Whatever his reason, The DoD must not "cherry pick" their programs of retirees because of age or health status as a way to meet budget targets.

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HISTORY OF TRICARE/CHAMPUS ELIGIBILITY FOR MEDICARE ELIGIBLES UNDER 65

1965, Congress established the Medicare Program under Title 18 of the Social Security Act. Medicare is a Federal Health Insurance Program administered in 2 parts, Part A and Part B. Part A is financed through taxes paid by workers and their employers (premium free to entitled individuals.) Part B is paid for in part by premiums from persons who voluntarily enroll in the program.

1966, the expressed intent of The Congress was to provide military retirees a premium free CHAMPUS benefit (in lieu of a reduced monthly compensation) equal to the Federal Employees Hi Option Blue Cross/Blue Shield or other popular fee-for-service FEHBP plan. Congress provides a Military Medical System with a priority for "wartime readiness." The

system cannot provide a health benefit to all military beneficiaries and therefore is not adequate when compared to the "employer-provided" benefit (FEHBP) offered equally to Federal Civilian Annuitants.

1972, The Social Security Amendments (42USC 1395c) expanded Medicare eligibility to entitled disabled CHAMPUS beneficiaries on or after 1 July 1973. There was a dual coverage benefit for all eligible beneficiaries until 1980 with no Part B requirement. The CHAMPUS regulations (DoD 6010.8 dated 10January1977) terminated CHAMPUS coverage effective January 1, 1978, for Medicare eligibles under age 65, but this was not supported in law. FY79 Testimony presented to the Senate Armed Services Committee by Mr. Vernon McKenzie, ASD(HA) described this termination of CHAMPUS as a "cost saving administrative action" that did not reduce medical coverage.

1980, CHAMPUS eligibility terminated for retired beneficiaries under age 65 who became entitled to Medicare Part A. Public Law 96-513, Sec. 511, an amendment to the "Defense Officer Personnel Management Act" signed on December 12, 1980.

1991, CHAMPUS restored as second payer to Medicare A and B for retired beneficiaries under age 65. FY92 Defense Appropriations Act, Public Law 102-190.

1994, Authorized Coordination of Benefits between Medicare and CHAMPUS specifying traditional reimbursement procedures. FY95 Defense Authorization Act, Public Law 103-337, Sec. 704.

1995, "Waiver of recoupment" for erroneous CHAMPUS payments. FY96, Sec. 743, which provides the authority to waive the collection of erroneous civilian health care payments from persons under the age of 65 who unknowingly lost TRICARE/CHAMPUS eligibility when they became eligible for Medicare as a result of a disability or End Stage Renal Disease. The period of waiver authority begins January 1, 1967, and ends on either the termination date of any special enrollment Medicare period established by law, or July 1, 1996, whichever is later. The rule was published in the Federal Register, December 4, 1997.

1995, "DATA Match" - Congress directs the administering Secretaries to develop a mechanism for notifying beneficiaries of their ineligibility for CHAMPUS when loss of eligibility is due to disability status or entitlement to Medicare Part A under age 65. Fy96 Defense Authorization Act, Sec. 734.

1997, January 16th letter from DoD (Health Affairs) to HCFA requesting a dialogue to develop viable options to provide "equitable relief" for CHAMPUS beneficiaries who are entitled to Medicare UNDER age 65. DoD(HA) acknowledges the inability of DoD to identify this category of beneficiaries in order to notify them of the change in law. The execution of a timely DATA exchange was also requested.

1997, Medicare Subvention Demonstration bills passed with FY98 Budget Amendment. **This Military Medicare Demo' is the only "at risk" Medicare HMO permitted to exclude the Medicare eligibles UNDER age 65 who suffer disability.** Are the Medicare elgibles UNDER 65 an "unfunded mandate" for MTF's? How will they be treated by the Military facility Commander who retains the legal ability to pick and choose the MTF patients according to the needs of their Graduate Medical Education Program and the MTF budget targets?

1997, Legislation waiving Medicare Part B late enrollment penalty **excludes disabled Medicare eligibles UNDER 65.** H. R. 598 by Rep. John Ensign, (R-Nev.) and S.912 by Sen. Chris Bond, (R-MO) waives the Part B premium penalty for OVER 65's. Is this discriminating omission of UNDER 65's intentional because DoD has no mechanism to identify

these eligibles or is it possible that these elected officials believe disabled persons are not deserving of EQUAL treatment by the law?

1998, Waiver of TRICARE PRIME enrollment fee for Medicare eligibles under age 65. DoD's final rule was published in the Federal Register with the effective date of March 26, 1998. However, DoD policy may not have been disseminated in time to be included in the initial marketing materials for Regions 1, 2, and 5.

1998, "Data Match" was accomplished by DEERS/HCFA on March 19, 1998 and DEERS letters were immediately mailed to 12,093 beneficiaries who had not purchased Part B and were without any outpatient coverage. The DEERS/HCFA DATA match identified 99,676 retired individuals who are Medicare eligible under age 65. If ASD(HA) last reported 23,733 dually covered beneficiaries, it would seem that about 76,000 military beneficiaries were erroneously listed with DEERS as having primary CHAMPUS eligibility.

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CONCLUSION:

We are very grateful to The Congress for the restoration of CHAMPUS benefits to retired military under age 65 who are dually entitled to Medicare A and enrolled in Part B. However, we are concerned about the lack of oversight and understanding by DoD to administer this dual benefit with full responsibility and accountability. DoD must now accept full responsibility to advise retired beneficiaries about both Medicare and TRICARE. If Congress persists in requiring Medicare B, then DoD must adjust TRICARE coverage to fully supplement Medicare similar to the Federal Employees Health Benefits Program and Medicare, waiving all cost shares and deductibles of TRICARE as a *"quid pro quo"* for Part B enrollment.

RECOMMENDATION:

1. I respectfully suggest that Congress direct The Department of Defense to designate a position to oversee the fair and equal administration of the health benefit as uniquely provided to Medicare beneficiaries under age 65. Funding for this centralized oversight task can be offset by savings accrued with the DoD money saved from shifting retired beneficiaries from TRICARE to Medicare A and B.

2. DoD must be directed by Congress to work out an arrangement of relief for disabled beneficiaries consistent with HCFA requirements for "Equitable Relief" considerations. Congress implied forgiveness of disabled persons with "Waiver of Recoupment" of erroneous CHAMPUS payments provision in FY96 Defense Authorization Act. The relief from Part B penalties should be similarly granted. Without "Equitable Relief," disabled retirees are not properly enrolled in Medicare Part B will find themselves without outpatient coverage for up to 15 months...an unconscionable, unintended consequence of law combining two incompatible Federal Health Programs.

3. Congress must consider repealing the Part B requirement based on the failure of DoD to implement the administrative process required to support this provision. Congress cannot continue to expand complex government programs with bureaucratic requirements without adding staff to accomplish the task.

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SL

Liaison

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AND ENVIRONMENT

4 JUN 1973

MEMORANDUM FOR The Assistant Secretaries of the Military Departments (M&RA)

SUBJECT: Medicare-CHAMPUS Dual Eligibility

Three provisions of the Social Security Act Amendments of 1972 affect eligibility or entitlement of CHAMPUS beneficiaries on or after 1 July 1973. The three provisions are:

a. Medicare for the disabled. Medicare protection is extended to persons entitled for not less than 24 consecutive months to cash benefits under the social security and railroad retirement programs because they are disabled. Coverage includes disabled workers at any age, disabled widows, and disabled dependent widowers between ages 50 and 65; women aged 50 or older who are entitled to mother's benefits and, for 24 months before the first month they would have been entitled to Medicare protection, met all the requirements for disability benefits except for actual filing of a disability claim; those aged 18 and over who receive social security benefits because they became disabled before reaching age 22; and disabled qualified railroad retirement annuitants. Medicare protection under this provision will begin with the later of (a) July 1973, and (b) the 25th consecutive month of an individual's entitlement to social security disability benefits and will terminate the month following the month notice of termination of disability benefits is mailed.

b. Chronic kidney disease deemed to constitute a disability for purposes of Medicare. Effective July 1, 1973, Medicare coverage is extended to individuals under age 65 who are currently or fully insured or entitled to monthly social security benefits, and to the spouses and dependent children of such individuals, who require hemodialysis or renal transplantation for chronic renal disease. Such individuals are deemed to be disabled for purposes of coverage under both parts of Medicare. Eligibility for coverage begins with the third month after the month in which a course of renal hemodialysis begins through the twelfth month after the month in which an individual had a transplant or dialysis terminates. Benefits include those of both parts of Medicare, with the usual deductibles and coinsurance. The Secretary is

authorized to limit reimbursement for treatment to kidney disease treatment centers that meet regulatory requirements.

c. Hospital insurance for the uninsured. Persons reaching age 65 who are ineligible for Medicare hospital insurance may enroll, on a voluntary basis, for such coverage under the same conditions as for supplementary medical insurance. Those who enroll will pay the full cost of the protection -- $33 a month at the beginning and more in later years as hospital costs rise; enrollment for supplementary medical insurance is also required. States and public organizations, through agreements with the Secretary, are permitted to purchase such protection on a group basis for their aged retired (or active) employees. Coverage under this provision will be effective on July 1, 1973.

With respect to these, the Office of the General Counsel has ruled that the provisions of section 1086(d) of title 10, United States Code, apply. Thus, for retired members and their dependents and survivors of deceased active duty and retired members, Medicare benefits will be deducted before determining CHAMPUS cost-sharing.

We do not know at the present time the effect of the new provisions on the CHAMPUS entitlement of dependents of active duty members, how many CHAMPUS beneficiaries may be affected by the new Medicare provisions, or the real magnitude of the dual eligibility problem. In view of this, we are attempting to develop a CHAMPUS implementation plan in coordination with the Social Security Administration. You will be provided with the additional details as soon as they have been developed.

Vernon McKenzie
Deputy Assistant Secretary of Defense
(Health Resources & Programs)

Attach. 1
no. 2

Memorandum for the Assistant Secretaries of Military Departments (M&RA)

dated 25 June 1973

SUBJECT: Medicare-CHAMPUS Eligibility.

Reference is made to the Memorandum from this office dated 4 June 1973, same subject.

We have not been able to complete the coordination with the Social Security Administration which we feel is necessary to establish a final CHAMPUS implementation of the three new Medicare eligibility provisions of the Social Security Act of 1972 which provide Medicare eligibility for some CHAMPUS beneficiaries.

Pending the completion of the necessary coordination of the CHAMPUS and Medicare claim procedures, the following procedures shall be placed in effect in the adjudication of CHAMPUS claims:

a. Claims from dependents of active duty members will be processed without regard to any possible Medicare eligibility.

b. Claims from retired members and dependents and survivors of deceased active duty and deceased retired members, will continue to be processed in accordance with procedures now in effect with respect to persons aged 65 and over who have Part A coverage under Medicare or Part B only. With respect to the Medicare 1972 Amendment coverage, the CHAMPUS cost-sharing shall be determined without regard to any new Medicare coverage unless the claim itself states the amount of the Medicare payment. In this case, the amount paid by Medicare shall be deducted in determining CHAMPUS cost-sharing under the procedure now in effect with respect to other health plans under 10 United States Code 1086d.

In view of the widespread interest in this matter among service families, your dissemination of this information is requested.

Vernon McKenzie
Deputy Assistant Secretary of Defense
(Health Resources & Programs)

Attachment #

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

JAN 16 1997

Honorable Bruce C. Vladeck, Ph.D.
Administrator, Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Vladeck:

I am writing to request your assistance on issues pertaining to CHAMPUS beneficiaries who are entitled to Medicare on the basis of disability.

As you are aware, beginning in 1992 CHAMPUS became second payer for beneficiaries entitled to Medicare on the basis of disability, only if they enroll in Medicare Part B. Unfortunately, the Department of Defense (DoD) has not and does not have the ability to identify this category of beneficiaries in order to notify them of the change in the law. As a result, many CHAMPUS beneficiaries were unaware of the change in the law, continued on CHAMPUS erroneously, and declined Part B, making them ineligible to use CHAMPUS as second payer under the new law. DoD is interested in pursuing equitable relief for those CHAMPUS beneficiaries entitled to Medicare due to disability.

Section 732 of the FY 1996 National Defense Authorization Act directs the administering Secretaries to develop a mechanism for notifying beneficiaries of their ineligibility for CHAMPUS when loss of eligibility is due to disability status. It is my understanding that the first step to implement this provision is to initiate a data exchange (on Medicare eligibles due to disability) from HCFA to DoD. Any assistance that you can provide to start the process of the data exchange and execute it in a timely manner would be greatly appreciated.

Further, I would like to initiate a dialogue on developing viable options (agreeable to both Departments) to provide equitable relief for CHAMPUS beneficiaries who are entitled to Medicare on the basis of disability. It would very beneficial if you could provide a point of contact within HCFA for this proposal of equitable relief for this category of beneficiaries as well as for the data exchange.

I look forward to working together to address this important issue. Please feel free to contact me with any questions or comments.

Sincerely,

Stephen C. Joseph, M.D., M.P.H.

Attachment #1

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

APR 24 1997

Honorable C. W. Bill Young
Chairman, Subcommittee on National Security
Committee on Appropriations
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter reports on TRICARE/CHAMPUS use by retirees and their families and the survivors of deceased members and former members under the age of 65 who are entitled to Medicare because of disability or end stage renal disease. It is provided in accordance with the Conference Report on the Defense Appropriations Act for Fiscal Year 1994, House Report 103-339. It is the seventh of the required semiannual reports which started March 1, 1994.

The first report contained complete background information, including a description of the early family member uncertainty before conflicts in law were resolved, and statistics from the effective date of the benefit, October 1, 1991. This report repeats comparative data in previous reports for Fiscal Years 1993 through 1995 and adds the most recent data available--for Fiscal Year 1996 and the first three months of Fiscal Year 1997. The use of TRICARE/CHAMPUS as secondary payor to Medicare continues to increase, but at a decreasing rate.

The Conference Report directed that paid benefits be tracked. Additional summary information based on when claims were paid is included as follows:

Fiscal Year 1993-96 and Three Months of FY 1997

FISCAL YEAR	UNIQUE USERS	CLAIMS PAID	GOVT. COSTS
1993	8,433	54,345	$ 5,860,082
1994	16,324	178,747	$16,075,917
1995	20,579	272,073	$22,661,822
1996	23,733	330,627	$26,357,041
3 Months Ending 12/96	16,730*	88,266	$ 7,198,466

* The number of different users with paid claims will not increase proportionately in the remainder of the fiscal year. A majority of the full year's unique users probably filed claims in the first 3 months.

AWL-1 #2

From Fiscal Year 1993 to 1994, as family member uncertainty about the benefit was clarified, unique users increased 93.6%; the number of paid claims increased 229%; and, TRICARE/CHAMPUS costs increased 174%. In Fiscal Years 1995 and 1996, the rate of increase slowed. For example, from Fiscal Year 1995 to 1996, the number of unique users with paid claims was up 15%, the number of claims increased 22%, and costs increased 16%.

Data for the first three months of Fiscal Year 1997 portend a further slowing of the trend. If these data are proportionate parts of the full year, the cost increase should be only about 10-12% for the full fiscal year compared to Fiscal Year 1996. Most of the cost increases are resulting from increased numbers of users. The average cost per unique user in Fiscal Year 1996 was $1,110.57, up less than 1% from the $1,101.21 a year earlier.

Outpatient drugs, which are not payable under Medicare but are TRICARE/CHAMPUS benefits, predictably are a significant part of TRICARE/CHAMPUS secondary payor costs for this dual eligible group of family members. Those who used the outpatient drug benefit accounted for 24% of TRICARE/CHAMPUS costs and 32% of the paid claims in Fiscal Year 1996. More than 40% of the users with claims paid in Fiscal Year 1996 submitted claims for drugs, at an average drug cost of $628 per user.

In addition to the 23,733 unique family members who had claims paid in Fiscal Year 1996, another 2,478 users submitted low dollar claims that did not exceed the deductible amounts and therefore did not generate TRICARE/CHAMPUS costs.

I hope this information is helpful. Thank you for your interest in and support of the Department's service members, retired members, and their families and their health care.

Sincerely,

Edward D. Martin

Edward D. Martin, M.D.
Acting Assistant Secretary of Defense

cc:
Honorable John P. Murtha
Ranking Democrat

Attach #3

Longview, Texas

Obscure Pentagon rule may ruin many veterans financially

By Jeff Nesmith
Cox News Service

WASHINGTON — The nation's armed services have failed to inform thousands of retired American veterans of an obscure rule that could leave them without crucial medical insurance if they become disabled.

Pentagon officials admit that they learn several hundred times each year of retirees who thought their health expenses were covered when they were not.

Many face financial ruin or quickly pay thousands of dollars' worth of medical bills that could have been covered by insurance had the retirees been properly informed.

At risk are former career armed service members who have retired from the military and subsequently been declared disabled by the Social Security Administration.

Regardless of whether it is related to military service, a retiree's disability entitles him or her to a monthly check from the Social Security Administration and Medicare coverage, even though the retiree is not yet 65.

Under the mistaken belief that they also have medical coverage under the Defense Department's Civilian Health and Medical Program for the Uniformed Services, or CHAMPUS, the veterans often run up medical bills of thousands of dollars.

When it is too late, they learn that because of a military-imposed Pentagon rule, neither Medicare nor CHAMPUS will pay.

While battling disabling or degenerative diseases, retirees sometimes find themselves being hounded by bill collectors from private health care providers and staring at a confusing morass of federal regulations.

The Pentagon acknowledges that retirees are unaware of the coverage gap because they were not warned of it in the briefings and printed materials routinely provided to them.

Here is what they are not told:

• When a retired veteran becomes disabled, he or she is eligible for Social Security payments and Medicare coverage from the Health Care Financing Administration, the government agency that administers Medicare. But in a cost-shifting move, the Defense Department routinely terminates CHAMPUS coverage for anyone who becomes eligible for Medicare.

While battling disabling or degenerative diseases, retirees sometimes find themselves being hounded by bill collectors from private health care providers and staring at a confusing morass of federal regulations.

• Like all Medicare enrollees, the retiree receives only "Part A," the plan that covers hospital expenses. He or she has the option to purchase "Part B" medical insurance for a monthly premium, currently $43.80.

• But retirees often decline Part B, unaware that their CHAMPUS coverage is being terminated and mistakenly believing CHAMPUS will pay for expenses normally covered by Medicare Part B.

• Meanwhile, the Defense Department will continue to provide CHAMPUS, as a "secondary" payer, to these same veterans — but only if they purchase Part B.

When retirees become eligible for Medicare by virtue of having reached their 65th birthday, the Defense Department sends them a letter which spells out the Part B requirement.

But the department has no way of knowing about retirees who become disabled and eligible for Medicare before they are 65. In fact, Pentagon officials don't even know the number of retirees affected. In 1994, officials estimated the number at up to 16,600.

Although the Defense Department Office of Health Affairs has been aware of the problem for years, officials have been dragging their feet since 1993 on a directive from Congress to perform a simple computer survey to identify the disabled retirees and inform them. Chris Peacock, a Health Care Financing Administration spokesman, said the agency could provide the Defense Department with a list of retirees who are enrolled in Medicare "immediately and at no charge."

Asked why the data match has not been run, even though Congress and Defense Department officials have been discussing it for more than four years, a Pentagon spokesman said in a written response: "The Department of Defense and HCFA (the Health Care Financing Administration) are in the process of negotiating the data release."

Occasionally a retiree will hire a lawyer or go to a member of Congress to fight the system.

When that happens, the Office of Health Affairs sometimes sends a form letter, acknowledging that the department failed to provide the necessary information to the retired service member.

"You should take this letter to your local Social Security Administration office and request consideration for equitable relief as a result of the misrepresentation by Department of Defense agents responsible for advising you of your benefit entitlement," the department says in the letter.

Then, if the Social Security Administration allows the retired veteran to purchase the Part B insurance for the back years when he or she had foregone the coverage, CHAMPUS also will be reinstated for those years.

The department acknowledges sending "about 500 to 600" of the form letters to disabled retirees each year. However, without the mandated computer survey, the department has no way of knowing how many retired service members have quietly taken second mortgages on their homes or dug into savings to pay medical bills which the Army, Navy, Air Force or Marines allowed them to believe would be paid for them.

Although the failure to inform retirees of the CHAMPUS-Medicare coverage gap has been a problem for over a decade, it has become more urgent in recent years because military downsizing has resulted in the closing of many military hospitals, said Edith Smith, of Springfield, Va., who has conducted a one-woman campaign to get Congress or the Defense Department to change the system.

"Before this, they (military retirees) could get care at military hospitals on a space-available basis," said Smith, wife of retired Marine Lt. Col. Vincent Smith. "But now there are 26 states that don't even have military hospitals."

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April 28, 1998

The Honorable John L. Mica
Chairman
Civil Service Subcommittee
Committee on Government Reform and Oversight
2157 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman:

On behalf of The Retired Enlisted Association (TREA), representing 100,000 active-duty and retired members of the Armed Forces and their spouses, we would like to thank you for holding an oversight hearing on the option of opening the Federal Employees Health Benefit Plan (FEHBP) to all military retirees.

With the continued down sizing of the Department of Defense budget and the impact of Base Realignment and Closures (BRAC) in military retiree communities, retirees are having increasing difficulty accessing healthcare. FEHBP ensures that military retirees will be able to receive healthcare quality that they have earned and entitled to by DoD.

As the Department of Defense budget has been continually downsized over recent years, the amount of funding directed to military retirees healthcare has decreased as well. This has lead to a decrease in staff to meet the needs of the retiree community. Further, the amount of "Space Available" care has been curtailed. It is this care that those over the age of 65 rely on if they desire care at military treatment facilities. As you are no doubt aware, military retirees over the age of 65 are forced out of the CHAMPUS/TRICARE system onto Medicare. It is important that these retirees are given the option to enroll in FEHBP.

FEHBP would enable retirees who live in non-catchment areas or areas affected by limited access to healthcare due to TRICARE limitations an alternative for their healthcare needs. This group of retirees should not lose their healthcare benefit because of where they decide to live. FEHBP is a nation-wide program that would particularly benefit those retirees who do not have access to military treatment facilities.

Secretary Cohen has already stated that two more rounds of base closures in 2001 and 2005 are necessary. Where will we meet the needs of the growing population of retirees who need access to healthcare with even fewer facilities? FEHBP is one feasible

alternative for meeting this challenge. After surveying our members that currently pay for CHAMPUS and Medicare supplements, we know that these members would like to have the option of enrolling in the FEHBP. Military retirees that have honorably served our country should receive the same benefits as those who dedicated their careers to government service.

Again, TREA would like to thank you for your leadership on this issue over the past two years. This issue is pertinent and needs to be addressed now because 30,000 veterans from World War II are dying on a monthly basis. We have limited time, we need action now.

Sincerely,

David Pahl

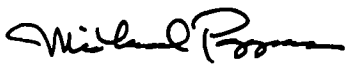
David Pahl
National President
The Retired Enlisted Association

Mr. MICA. Without objection we will leave the record open for 10 days for additional comments for Members who were unable to be with us and others who would like to submit statements for the record.

There being no further business to come before the House Civil Service Subcommittee, this meeting is adjourned.

[Whereupon, at 4:50 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Michael Pappas follows:]



Opening Statement of Representative Michael Pappas
Vice Chairman Subcommittee on Civil Service
Hearing on FEHBP /TRICARE: FEHBP as a compliment to Military Health Care
April 29, 1998

Mr. Chairman, Thank you for calling this hearing today which will explore a very serious issue and hopefully raise awareness regarding the treatment and access of active duty dependents, military retirees, and other qualifying participants to the military's healthcare system. We all agree that our military personnel should have access to the best possible health care system that we can provide them. The extraordinary sacrifice that each member of the armed forces makes everyday to protect our country demands that we in the Congress make sure they receive it.

Access to proper heath care is the key and I was disturbed to learn that in some cases proper access is not occurring on a regular basis particularly among retirees and other dependents. Many of these dependents and retirees are on Medicare and could potentially receive care at DOD facilities. This policy known as Medicare Subvention, would direct Medicare to reimburse DOD for care provided at military facilities to Medicare-eligible

beneficiaries. I would argue this could provide the funding necessary to make DOD care available to far more beneficiaries -something that is clearly not happening now. I was proud to co-sponsor Mr. Moran's bill, HR 1766 and Mr. Hefley's bills H.R. 192, and HR 414 which would allow for a demonstration project for Medicare subvention to take place. In my district alone there are over 12,000 military retirees out of Fort Monmouth and over 3,000 military personnel at Naval Weapons Station Earle that could stand to benefit if this policy was adopted by the Congress nationwide. While I am concerned and welcome this hearing about what such subvention would do on a broader scale to military readiness, I believe the demonstration program is a prudent first step toward better access for military retirees and others.

Moreover, this Congress must challenge every federal insurance plan, every federal health care facility, and every individual covered under federal benefits to work together for the best health care for our military retirees, government employees, and others covered under federal benefits. We have a DOD military health care system and VA health care system. In this age of limited federal dollars, we cannot afford to have turf battles. The federal

healthcare programs in place now should be enhanced to further health care, however duplication should be reduced and improved care for all should be the unifying goal of everyone involved in this debate.

Mr. Chairman in many ways our military personnel, retirees, and their dependents are clearly among the most important resources we have as a nation. We need to find ways to give them the best healthcare system and today's hearing marks an important step toward reaching that goal.

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